June 1953

Medical Economics



How We Apportion Fees Ethically

Also in this issue:

What Growth Stocks Offer You

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June 1953

Medical Economics

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'We're not interested in excuses,' says this labor leader. 'Either voluntary health insurance will do the job, or we'll get a compulsory Federal system'

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Published monthly and copyrighted 1953 Medical Economics, Inc., 210 Orchard St., East Rutherford, N.J.

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Panorama

Congressman criticizes V.A. hospital admissions policy • $10 million drive under way for medical education • Guinea pig M.D. wins bravery award • A.M.A. 'lobby' second biggest in Washington

Chiropractors Defeated

New York State physicians have won a battle to keep their state from joining the ranks of the many that license chiropractors. But medicine had a close call in the State Senate: The bill to license the cultists was turned down by a vote of only thirty-two to twenty-four.

Enlarge Casberg Role

In a move that tends to increase civilian control over the military, the Pentagon has conferred a new title and greater power on its top medical man, Dr. Melvin A. Casberg.

Formerly chairman of the now defunct Armed Forces Medical Policy Council, Casberg has been named assistant to the Secretary of Defense, in charge of health and medical matters. Casberg still has an advisory council, but it's composed entirely of civilians.

The Surgeons General, who, as members of the old council, helped Casberg make policy, no longer operate at that level. Instead, they now simply carry out whatever policies Casberg sets.

Medicine Gets Windfall

Medical research turns out to be the unexpected beneficiary of the recent hassle between Secretary of Defense Charles E. Wilson and the Senate.

In bowing to the Senate's demand that he unload his extensive holdings in General Motors before entering the Government, Wilson gave $100,000 worth of G.M. shares to Harper Hospital in Detroit. Income from the stock was to be used chiefly, he said, for research into heart disease (which killed his brother at the age of 50).

Support A.C.S. Head

Dr. Paul R. Hawley's pronouncements on fee splitting may have antagonized a good many medical men; but the regents of the American College of Surgeons are solidly behind their chief spokesman.

At a recent Los Angeles meeting, the sixteen-man board of regents issued a statement that medical men "should welcome the opportunity to profit from criticism" like Hawley's.

Added the A.C.S. board: "It is inconceivable that the medical profession as a whole can be injured by exposing and weeding out those relatively few who violate or evade . . . high traditions."

V.A. Care Rapped Anew

Representative John Phillips (R., Calif.) says that a subcommittee he heads, which handles V.A. appropriations, has investigated 500 veter-

Medical Educators Campaign for Funds

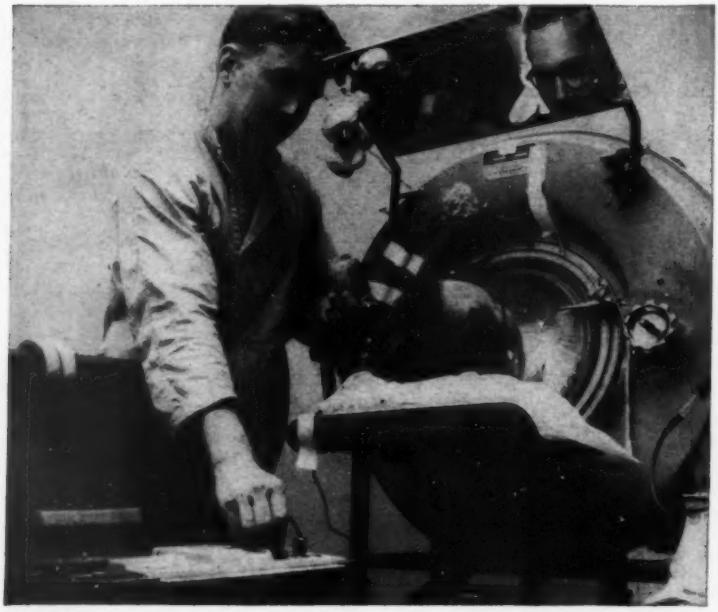


Across the country, business leaders and medical men are joining hands in an effort to raise the funds needed to balance the books of America's medical schools. The 1953 target of the National Fund for Medical Education: $10 million. Here, at a Denver regional meeting, two businessmen confer with three physicians. Left to right are Carl A. Norgren, Colby M. Chester, and Drs. Ward Darley, Frank H. Lahey, and Robert C. Lewis.

ans with non-service-connected ailments who have received treatment in V.A. hospitals as "indigents."

Of this number, says Phillips, 336 have annual incomes from $4,000 to $50,000; and twenty-five own property ranging in value from $20,000 to $500,000. Such a lax policy of admitting men to V.A. hospitals, warns Phillips, will "take us

Doctor in Iron Lung Is Disk Jockey



One day, Lieut. William Owen of Detroit was a young Army physician, interning at Walter Reed Army Medical Center in Washington, D.C. The next day, he was himself a patient—struck down by polio. But even in an iron lung, Owen wanted to do *something* for the other patients. So he worked up a disk jockey show that he records on tape, with the aid of a wounded flier, for the hospital radio station. Said President Eisenhower in a letter of praise: "No matter how great a man's burden may be, he can, if he will, find ways in which he can help lighten the burdens which others are bearing."

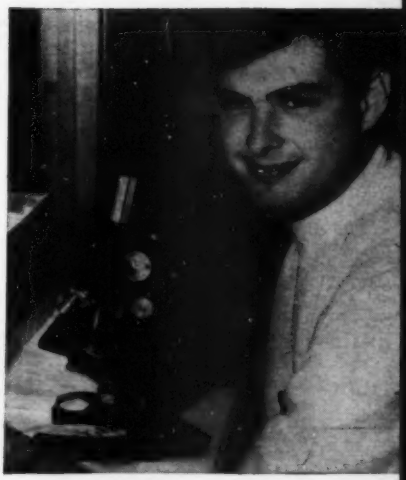
into socialized medicine without our realizing it."

American Legion Commander Lewis K. Gough has called for more thorough investigation of such cases.

Doctor Cited as Hero

When Lloyd T. Koritz was a medical student at the University of Illinois, he volunteered himself for use in experiments on new methods of artificial respiration. (On one occasion, he had to hang unconscious from a telephone pole. Another time, he had to eat a pound of raw liver every day for thirty days.)

After serving as a guinea pig for two years, Koritz became an interne in Chicago's Cook County Hospital. One of the 26-year-old doctor's les-



Lloyd T. Koritz
A pound of raw liver daily



Lewis K. Gough
'We'll make an investigation'



John Phillips
Cites $50,000-a-year 'indigents'

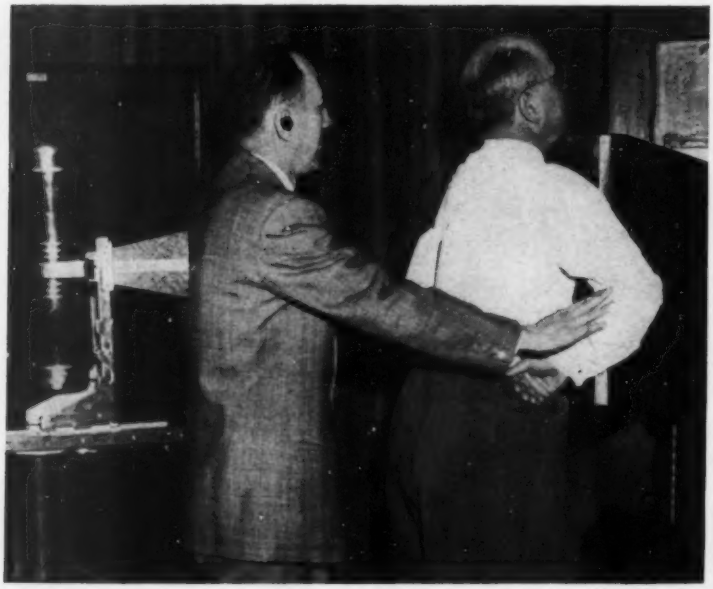
ser ordeals lately has been the acceptance of the Walter Reed Society's award for bravery.

Diathermy Reminder

Starting July 1, there'll be no further complaints about interference with radio reception from diathermy equipment. At least, that's what the Federal Communications Commission expects.

The end of this month, you'll recall, marks the wind-up of the period of grace for use of equipment manufactured before July 1, 1947.

Physicians Get Dose of Own Medicine



When the nation's family doctors trouped to St. Louis for this year's meeting of the American Academy of General Practice, they found themselves on a spot usually reserved for patients. The 5,000 medical men at the convention were invited to submit to free chest X-rays, to be interpreted immediately. First in line among the chest-conscious physicians was the new A.A.G.P. president, Dr. U. R. Bryner of Salt Lake City (in shirt sleeves, above).

So if you're still using the "old-fashioned" kind, this is a reminder that time is crowding you.

M.D. 'Lobby' Ranks 2nd

Among so-called Washington lobbies, the A.M.A. ranked as second heaviest spender last year. Even after dropping its special campaign against compulsory health insurance, the A.M.A. reported an outlay of $309,514.

The top spender, the National Association of Electric Companies, paid out $477,941.

Model of a Modern Medical Man



By acting on television and modeling professionally, Robert William Baird paid his way through medical school in New York. Dr. Baird's sister, Myra, also is a well qualified model—as can be plainly seen. Here, at a hospital hobby show, the Bairds display doctor and nurse cut-out dolls for which they recently posed. Baird, a New Yorker, is now a resident at the Flower and Fifth Avenue Hospitals.

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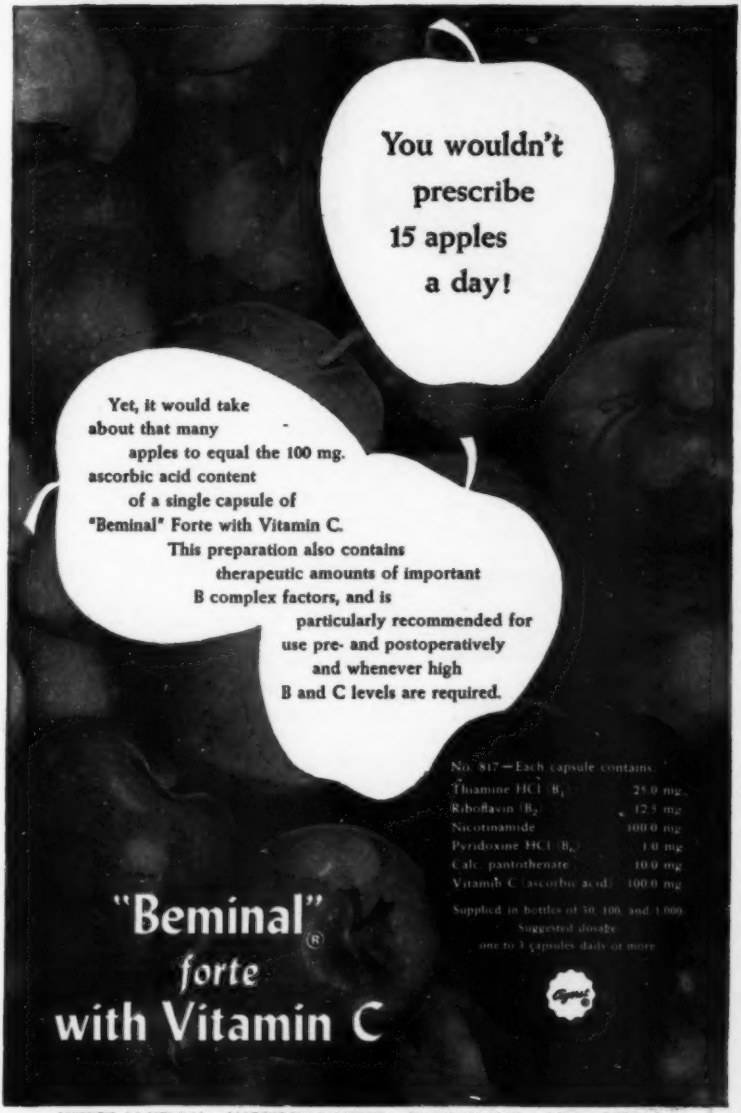
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1. Stritzler, C.; Fishman, I. M., and Laurens, S.: *Transactions New York Acad. Sc., 13*:31, Nov., 1950.

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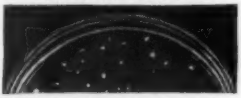
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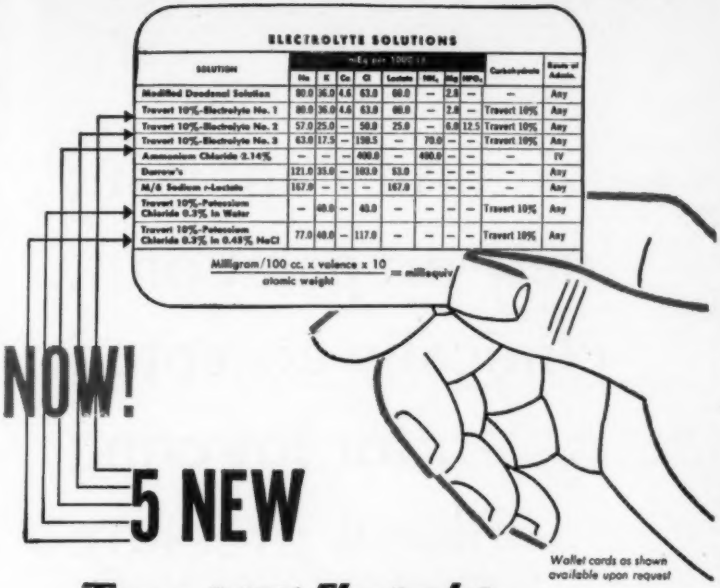
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(1) Crumpton, C. W. et al.: Abstract, Society for Pharm. & Exper. Therap., September 8-10, 1952, J. Pharm. & Exper. Therap., 106:378, December, 1952. (2) Currens, J. H. et al.: Abstract, Program, American Heart Assn., April 18-19, 1952. (3) Meilman, E., and Krayer, O.: Circulation, 6:212, August, 1952. (4) Hoobler, S. W. et al.: Ann. Internal Med., 37:465, September, 1952. (5) Smirk, F. H., and Chapman, O. W.: Am. Heart J., 43:586, 1952. (6) Nash, H. A., and Brooker, R. M.: Abstracts of Papers, 122nd Meeting Am. Chem. Soc. (September, 1952) p. 231. (7) Nash, H. A., and Brooker, R. M.: J. Am. Chem. Soc. (in Press).

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[1]*Smith, D. T.: Disturbance of Normal Bacterial Ecology by Administration of Antibiotics with Development of New Clinical Syndromes, Annals Int. Med., 37:1123, (Dec.) 1952.*

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1. Exper. Med. & Surg. 9:90, *1951. 2. Rev. Gastroenterol.*, 19:660, *1952.*

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NAUSEA OF PREGNANCY

FOOD POISONING

ENTERIC INFECTIONS





For every age group...

this Broad Spectrum DIETARY SUPPLEMENT

Regardless of cause or patient age, the need for dietary supplementation frequently arises. Whenever such supplementation is indicated to round out the intake of essential nutrients, a broad spectrum supplement—one that supplies notable amounts of all important nutrients—will serve the patient optimally.

Ovaltine in milk, a delicious food drink, has long been widely prescribed for this purpose. As the appended table shows, it supplies substantial amounts of virtually all nutrients known to take part in metabolism, from biologically top-grade proteins, through the gamut of the essential vitamins, to the minerals, even those needed in trace amounts.

Whenever the patient's nutritional state must be improved, Ovaltine in milk deserves first consideration.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.

Ovaltine

Three Servings of Ovaltine in Milk Recommended for Daily Use Provide the Following Amounts of Nutrients

(Each serving made of ½ oz. of Ovaltine and 8 fl. oz. of whole milk)

MINERALS		VITAMINS	
*CALCIUM	1.12 Gm.	*ASCORBIC ACID	37 mg.
CHLORINE	900 mg.	BIOTIN	0.03 mg.
COBALT	0.006 mg.	CHOLINE	200 mg.
*COPPER	0.7 mg.	FOLIC ACID	0.05 mg.
FLUORINE	3.0 mg.	*NIACIN	6.7 mg.
*IODINE	0.15 mg.	PANTOTHENIC ACID	3.0 mg.
*IRON	12 mg.	PYRIDOXINE	0.6 mg.
MAGNESIUM	120 mg.	*RIBOFLAVIN	2.0 mg.
MANGANESE	0.4 mg.	*THIAMINE	1.2 mg.
*PHOSPHORUS	948 mg.	*VITAMIN A	3200 I.U.
POTASSIUM	1300 mg.	VITAMIN B_{12}	0.005 mg.
SODIUM	560 mg.	*VITAMIN D	420 I.U.
ZINC	2.6 mg.		

*PROTEIN (biologically complete)	32 Gm.
*CARBOHYDRATE	65 Gm.
*LIPIDS	30 Gm.

*Nutrients for which daily dietary allowances are recommended by the National Research Council.



for your
peptic ulcer
patients . . .

Antrenyl™
bromide
OXYPHENONIUM BROMIDE CIBA

New High Potency
Anticholinergic with
No Bitter Aftertaste

As adjunctive therapy in your standard peptic ulcer regimen,* Antrenyl offers potent anticholinergic action to inhibit motility of the gastrointestinal tract and gastric secretion.

Although Antrenyl is one of the most potent of all anticholinergic agents, it rarely causes esophageal or gastric irritation and has no bitter aftertaste. In individualized doses, it is well tolerated and side effects are absent or generally mild.

In one study[1] patients receiving Antrenyl obtained relief from acute symptoms within 24 to 36 hours. Dosage was individually adjusted at 5 to 10 mg. four times a day. Side effects were adjudged less pronounced than those of other similar agents ordinarily used in the management of peptic ulcer.

Prescribe Antrenyl in your next case of peptic ulcer and spasm of the gastrointestinal tract. Available as tablets, 5 mg., scored, bottles of 100; and syrup, 5 mg. per teaspoonful (4 cc.), bottles of 1 pint.

Ciba Pharmaceutical Products, Inc., Summit, N. J.

Leading gastroenterologists recommend:

rest
sedation
antacids
nonirritating diet
anticholinergics

Ciba

1. Rogers, M. P., and Gray, C. L.: *Am. J. Digest. Dis.* 19:180, 1952.

2/1896M

Sidelights

A plan for apportioning fees ethically • Magnuson's detractors • The rebuilding job in Korea • Borrow for health? Why not?

Apportioning Fees

Official pronouncements against fee splitting are made, presumably, for the well-being of the patient. But, ironically enough, they sometimes seem only to complicate things for him. For instance:

Physicians who take these pronouncements literally may get the idea that any apportionment of fees is unethical. Actually, there are some perfectly legitimate ways of apportioning fees—ways that work to the advantage of patients as well as doctors.

One such plan is described elsewhere in this issue. It offers the patient some advantages he's not likely to overlook:

¶ It tells him in advance what the *total* cost of his operation will be;

¶ It helps him to understand the part played by his family doctor when the latter is a member of the surgical team; and

¶ It gives him some assurance that each member of the team will be compensated fairly for services performed.

One constructive plan like this, we maintain, does more to resolve a sticky problem than a dozen edicts from above.

Unwarranted Attack

Federal health and hospital programs now cost the nation almost $2 billion a year. To get the most for this money, the Government must have the aid and counsel of medicine's best brains. Trouble is: The men who could be of greatest help are often the least available.

If you're wondering why, just ponder the case of Dr. Paul B. Magnuson.

Here, a few years ago, was one of private medicine's special heroes. Why? Because, while chief medical director of the Veterans Administration, he had the courage to speak up when he felt the bureaucrats were trying to run the V.A. medical program. His temerity cost him his job.

Less than a year later, he agreed to head President Truman's controversial Commission on the Health Needs of the Nation. He took the job, we believe, because he felt the commission would be allowed to do

Announcing

Rauwiloid

a new and distinctly different hypotensive agent



Outstanding for:

- **its ability to control associated symptoms**
- **its freedom from side actions**

AN ORIGINAL RIKER RESEARCH PRODUCT

obtained from *Rauwolfia serpentina*

In mild and moderate hypertension . . .

Rauwiloid

What it is: Rauwiloid represents an alkaloidal extract of the root of *Rauwolfia serpentina*, found chiefly in India. The hypotensive action of this drug has long been known, but a purified, standardized dosage form heretofore has not been available. In the form of Rauwiloid, all the advantageous features of the drug are provided in a reproducible alkaloidal mixture for the treatment of hypertension. Each batch of Rauwiloid is biologically tested in dogs for its effectiveness in producing drop in blood pressure, bradycardia, and sedation.

What it does: The hypotensive action of *Rauwolfia serpentina* is of moderate intensity.[1] It is not apparent for several days after therapy is initiated and does not attain its maximum extent for weeks or even months.[2] When therapy is stopped, the hypotensive effect persists for some time.[3] Coincidentally with the hypotensive action, Rauwiloid produces a mild bradycardia, especially appreciated in the presence of the tachycardia which so frequently disturbs the hypertensive patient. A significant feature of Rauwiloid is the distinct sense of well-being and emotional calm it induces, as well as the prompt relief of symptoms experienced by the patient. In a series of 326 patients, drowsiness was noted in only seven.

The entire daily dose of Rauwiloid may be taken at one time, for instance upon retiring. Rauwiloid produces no undesirable side actions, even when given in excessive amounts. Dosage therefore is not critical, hence dosage calculation is not necessary. Rauwiloid is not a ganglionic or adrenergic blocking agent, and does not interfere with postural reflexes.

Available evidence shows that when a second hypotensive agent is given with *Rauwolfia serpentina*, its effect is exerted in addition to that of *Rauwolfia serpentina*.[1]

NOTE THESE ADVANTAGES

The desirable hypotensive action of Rauwiloid is characterized by these advantageous features. It produces

1. Pronounced subjective improvement
2. Emotional calm especially appreciated by apprehensive patients
3. Mild bradycardia, not tachycardia
4. No undesirable side actions
5. No toxic effects; there are no known contraindications

Indications: Rauwiloid is the medication of choice in mild and moderate hypertension; in severe and malignant hypertension its synergistic properties are valuably employed with other medication. There are no known contraindications.

Administration and Dosage: The initial dose of Rauwiloid is 4 mg. daily, given as a single dose at night, and continued until the desired effect has been attained. Maintenance dosage at 2 mg. daily can be instituted when symptomatic and objective improvement indicates, usually after one or two months.

How Supplied: Rauwiloid is available in 2 mg. tablets in bottles of 60, a month's supply of medication.

In severe or resistant hypertension . . .

Rauwiloid + Veriloid®

Rauwiloid + Veriloid provides the greater hypotensive response required in severe or resistant hypertension. In this combination, consisting of 1 mg. of Rauwiloid and 3 mg. of Veriloid, the effect of the Veriloid is superimposed upon that of the Rauwiloid. The response appears to be greater than simple summation of the two effects, pointing to synergistic potentiation. The calming influence of Rauwiloid makes it possible for more patients to tolerate Veriloid, with less likelihood of side actions.

The average dose of Rauwiloid + Veriloid is one tablet three times daily, at intervals of not less than four hours, ideally after meals. This quantity may be increased to four tablets daily, especially after the response to Rauwiloid is fully apparent.

Supplied in bottles of 100, an average month's supply.

RIKER LABORATORIES, INC.

8480 BEVERLY BLVD., LOS ANGELES 48, CALIF.

6. Continuous, round-the-clock effect from once-a-day dosage
7. Hypotensive action synergistic with more potent hypotensive agents
8. No economic hardship for the patient; notably low in price for active or maintenance therapy, making it particularly advantageous in mild hypertension

The physician will appreciate the opportunity electively to lower the blood pressure without side actions with the aim of arresting the hypertensive process.

References:

1. Wilkins, R.W., and Judson, W.E.: The Use of Rauwolfia Serpentina in Hypertensive Patients, New England J. Med. *248*:48 (Jan. 8) 1953.
2. Wilkins, R.W.; Judson, W.E., and Stanton, J.R.: Preliminary Observations on Rauwolfia Serpentina in Hypertensive Patients, Proc. New England Cardiovas. Soc., 1951-1952, p. 34.
3. Vakil, R.J.: A Clinical Trial of Rauwolfia Serpentina in Essential Hypertension, Brit. Heart J. *11*:350 (Oct.) 1949.

a non-political job in an area where objective data were sadly lacking.

Yet neither his good intentions nor his known distaste for bureaucracy kept him from being verbally tarred and feathered by his own profession. At the 1952 meeting of the A.M.A. House of Delegates, Magnuson heard himself branded as, among other things, "an unwitting captive of the forces of socialization." And the attack on him has, if anything, redoubled since the commission issued its report early this year.

True, the report contains much that we in the profession did not relish. But that, we submit, is no reason why Magnuson *personally* should have become anathema.

The facts show, simply, that

(1) Magnuson agreed to head a President's commission investigating the health needs of the nation; that

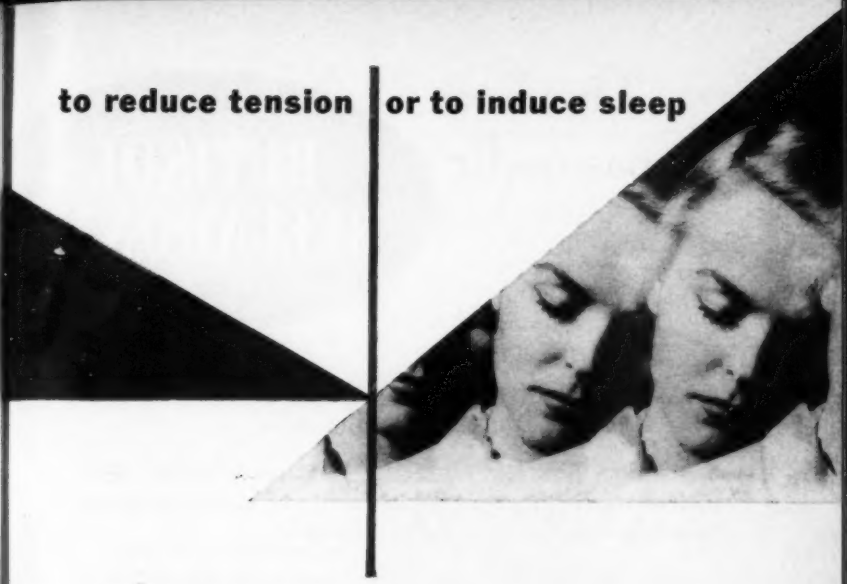
(2) Working against a tight deadline, this commission made a lot of recommendations, including some we don't agree with; and that

(3) A number of physicians now seem to think that Magnuson is bent on sabotaging the profession.

Would he have seemed to us a more admirable fellow had he started his assignment with the aim of "proving" that there's nothing at all the matter with the nation's health? We doubt that. The great bulk of doctors, we feel, are more interested in preserving freedom of inquiry



to reduce tension | or to induce sleep



CARBRITAL®

calms the restless...rests the sleepless

CARBRITAL is invaluable for reducing daytime tension or inducing prompt, refreshing sleep at night. It combines the hypnotic action of sodium pentobarbital, plus the milder hypnotic but more prolonged sedative effect of carbromal. With CARBRITAL, patients relax easily, fall asleep quickly, and awaken refreshed and alert.

CARBRITAL is useful in a wide variety of indications including insomnia, nervous tension, and preoperative or obstetrical preparation.

Each CARBRITAL KAPSEAL (Full-strength) contains:	
Pentobarbital sodium	1½ grains
Carbromal	4 grains
Each CARBRITAL KAPSEAL (Half-strength) contains:	
Pentobarbital sodium	¾ grain
Carbromal	2 grains
Each fluidounce of CARBRITAL ELIXIR contains:	
Pentobarbital sodium	2 grains
Carbromal	6 grains

CARBRITAL KAPSEALS, full or half-strength, may be taken by adults in doses of one or more, on schedules determined by the physician. Children may be given ½ to 1 teaspoonful of CARBRITAL ELIXIR; adults 1 to 2 teaspoonfuls or more as required.

MEDICAMENTA VERA

Parke, Davis & Company

The new antispasmodic

BUTISOL-BELLADONNA

. . . produces a more effective antispasmodic action than either belladonna or Butisol Sodium alone,

. . . provides Butisol Sodium, the "daytime sedative", with mild, relatively prolonged action most useful in "functional disorders" and "certain organic diseases"[1],

. . . with naturally occurring belladonna—not the synthetic alkaloids,

. . . is unusually palatable—a light, pleasant tasting elixir, colored an attractive orange-red.

FORMULA:
5 cc. (one teaspoonful) of the elixir represents:

Butisol Sodium (Sodium 5-Ethyl-5-Secondary Butyl Barbiturate McNeil) . . . . . 10 mg. (1/6 gr.)
Ext. Belladonna . . 15 mg. (1/4 gr.)

SUPPLIED:
Elixir Butisol-Belladonna in bottles of one pint and one gallon.

Samples on request.

1. Dripps, R. D.: Selective Utilization of Barbiturates, J.A.M.A. *139*:148-150 (Jan. 15) 1949.

McNEIL
LABORATORIES, INC.

PHI

In irritable colon . . . emotional diarrhea . . .

peptic ulcer . . . pyloro-duodenal irritability . . .

pyrosis . . .

functional dysmenorrhea . . .

diarrhea due to acute

gastroenteritis or

ulcerative colitis . . .



PHILADELPHIA 32, PA.

than in setting up a system of thought control for medicine.

But we also feel that to have belabored Magnuson has put doctors in a bad light. It will certainly be an unhealthy thing for the profession—to say nothing of the public—if medical men of Magnuson's stature ever decide to turn their backs on Government work.

Investment Opportunity

What one American medical man saw in Korea is recounted further along in this issue. Dr. Howard Rusk's story is not a pleasant one. It's full of statistics on war orphans, amputees, and appalling shortages of medical personnel. After a thorough study of the medical needs of the country, Dr. Rusk's committee has found, he says, that the medical plight of Korea is nothing short of tragic. If and when peace comes, he adds, the Koreans can hope to get back on their feet only through an extensive aid program.

The major bright spot in Rusk's grim story is that plans for doing the job have already been made. Both the United Nations and a number of volunteer organizations are tackling the problems of rebuilding by providing technical assistance and money.

Still another bright spot is this: Rusk's story highlights the spectacular returns that an investment in the Korean medical-assistance program can bring. Because the American dollar stretches so far in Korea, it's possible to get some bargain results. For example, twenty cents will maintain an orphan child for a day; and $500 will pay all the expenses of a badly needed medical student for a year.

Admittedly, American physicians have little trouble finding places where they can put spare money to good use. Yet it's hard to imagine a place where that money will buy *more* than it will in Korea.

Borrowing for Health

If you doubt the propriety of suggesting that patients finance expensive medical care via installment bank loans, the following figures may reassure you:

There's been a 700 per cent increase in installment credit since 1945. Then, Americans owed about $2 billion; now they owe $16 billion. And they're paying off this sum, on time, for homes, automobiles, TV sets, and—somewhere down the list—medical service.

Credit men don't necessarily maintain that all this indebtedness is good for the economy (though most of them seem pretty happy about it). But the variety of bank-sponsored health-financing plans described elsewhere in this issue must still be recognized as part of a definite, increasing trend.

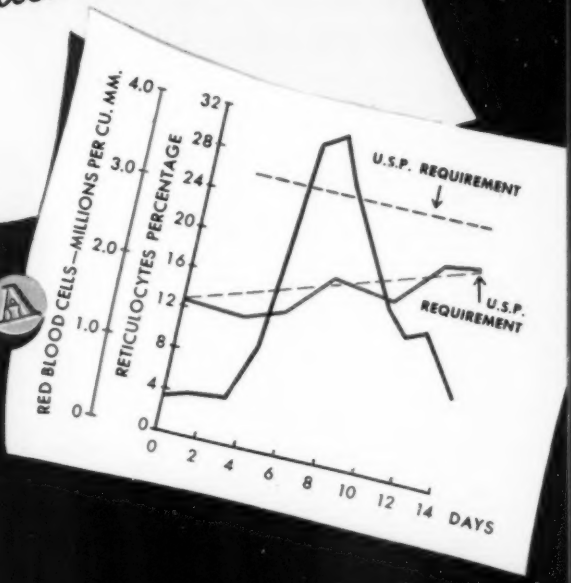
Besides, can you think of a better reason for a person to borrow than to safeguard or regain his health?

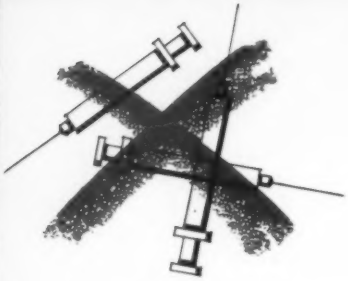
XUM

DEPARTMENT OF HEMATO

Clinical Report

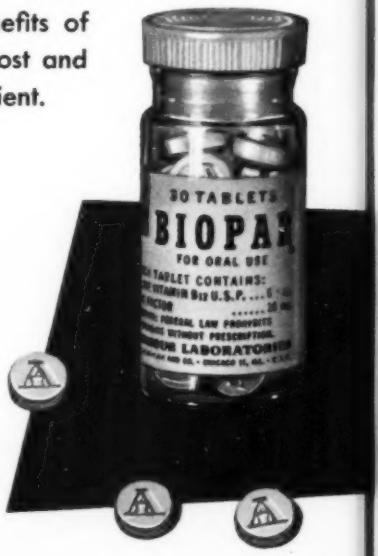
Biopar tablets are effective oral replacement for injectable vitamin B_{12}





Biopar tablets can be given with confidence in conditions which were previously considered exclusive indications for parenteral vitamin B_{12}, including pernicious anemia in relapse. Only small doses of vitamin B_{12} are required per tablet, due to the powerful potentiating effect of a new intrinsic factor preparation developed by The Armour Laboratories.

Biopar, offering two-fold economy—low cost per dose, and the economy of oral therapy over injections—provides the full benefits of vitamin B_{12} therapy at minimal cost and maximal convenience to the patient.



BIOPAR®

TABLETS

Each Biopar Tablet contains:
Crystalline Vitamin B_{12} U.S.P. . . .6 mcg.
Intrinsic Factor. . . . . 30 mg.
Supplied: In bottles of 30 tablets.

THE ARMOUR LABORATORIES
A DIVISION OF ARMOUR AND COMPANY • CHICAGO 11, ILLINOIS
world-wide dependability

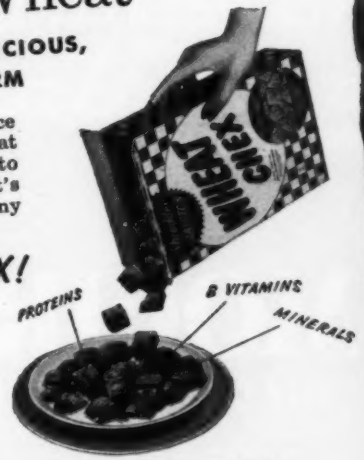
PHYSIOLOGIC THERAPEUTICS THROUGH BIORESEARCH

Whole Wheat

IN ITS MOST DELICIOUS, CONVENIENT FORM

When the convenience offered by a ready-to-eat cereal is required to assure the patient's cooperation, so many doctors recommend

WHEAT CHEX!



WHEAT CHEX is made of whole wheat, ready to eat without fixing.

It's bite size for easy eating. Specially prepared for easy digestion. Has a delicious flavor that stimulates lagging appetites. Lasting crispness in cream or milk to make the last bite as tempting as the first.

Recommend **WHEAT CHEX** for breakfast—for between-meal and bedtime snacks instead of sweets.



DELICIOUS! NUTRITIOUS! IT'S WHOLE WHEAT!

FOR POSITIVE IRON
AND CALCIUM BALANCES
IN PREGNANCY———

MOL-IRON®

WITH CALCIUM AND VITAMIN D

This unusually effective and well tolerated hematinic,* is supplemented specifically to maintain high calcium-phosphorus as well as iron levels during pregnancy and lactation.

* To date 12 reports on Mol-Iron have appeared in medical literature; all concur in the conclusion that Mol-Iron is more effective and better tolerated than unmodified ferrous sulfate and other iron salts.

Each soft gelatin capsule contains:

Mol-Iron (*molybdenized ferrous sulfate*)	198 mg.
Dicalcium phosphate	869 mg.
Vitamin D_3	200 units

Dosage: prophylactic, 1 capsule t.i.d.
therapeutic, 2 capsules t.i.d.

Supplied: bottles of 100 and 1000 capsules.

White's WHITE LABORATORIES INC. KENILWORTH N. J.

WITH

RAYTHEON

MICROWAVE RADAR DIATHERMY

Microtherm

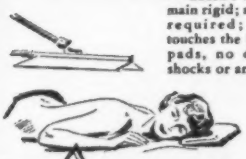


YOU CAN RELAX

Dosage may be predetermined and controlled over large and small areas, and may be precisely duplicated in successive treatments.

YOUR PATIENT CAN RELAX

— doesn't have to remain rigid; no tuning is required; nothing touches the body — no pads, no danger of shocks or arcs.



YOUR NEIGHBOR CAN RELAX



and enjoy his television with avoidance of interference. Microtherm's radar wave length, 2450 megacycles, is way above TV wave range (not over 920 megacycles)



MICROTHERM for high clinical efficiency — provides penetrating energy for deep heating — proper temperature ratio between fat and vascular tissue — effective production of active hyperemia — correct relationship between cutaneous and muscle temperature.

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Split-thickness grafts.
Arm at first dressing one
week after operation.

To give you fine-quality motion-picture records

with ease and convenience . . .

Cine-Kodak Royal Magazine Camera: Now you can make superb black-and-white or full-color motion pictures as easily as ordinary snapshots. Yet the Royal is capable of a variety of effects, can handle a wide range of situations.

Consider these facts: Cine-Kodak Royal takes film in magazines, loads in 3 seconds. Its three-way exposure lever

permits normal operation and it can be locked in running position or set for single-frame exposure for animation, special titles, etc. There are three speeds including real slow motion. The enclosed optical finder has parallax indicators to show the field covered with standard, wide-angle, or any of eight telephoto lenses which magnify subjects as much as six times. With the Cine-Kodak Royal you can get in close on difficult subjects.

Accessories include a Focusing Finder to permit through-the-lens subject viewing for ultra-precise composition; Cine-Kodak Lens Spacer Rings for greatly magnified pictures of subjects as small as ½ inch.

Two models available: with *f*/2.8 Kodak Cine Ektanon Lens, $147.50; with *f*/1.9 Kodak Cine Ektar Lens, $176.25. Prices list, include Federal Tax, are subject to change without notice.

For further information see your Kodak photographic dealer or write:

EASTMAN KODAK COMPANY
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Complete line of Kodak Photographic Products for the Medical Profession includes: **cameras and projectors for slides and motion-pictures; film—full color and black-and-white (including infrared); papers, processing chemicals; microfilming equipment and microfilm.**

Serving medical progress through Photography and Radiography

Kodak
TRADE-MARK

why DESITIN®

hemorrhoidal

SUPPOSITORIES

with **cod liver oil**

are safe, conservative therapy in **hemorrhoids**

more effective . . . because they provide healing crude Norwegian cod liver oil (rich in vitamins A and D and unsaturated fatty acids, in proper ratio for maximum efficacy).

more comforting . . . emollient, protective, lubricant to relieve pain, itching and irritation rapidly . . . to minimize bleeding and reduce congestion.

safe, conservative . . . . . contain no styptics, narcotics or local anesthetics, so they will not mask serious rectal disease. Easy to insert and retain.



Composition of Desitin Suppositories: crude Norwegian cod liver oil, lanolin, zinc oxide, bismuth subgallate, balsam peru, cocoa butter base. Boxes of 12 foil wrapped suppositories.

for **samples,** please write . . . . **DESITIN** CHEMICAL COMPANY ●
70 Ship Street • Providence 2, R. I.

Why Obedrin

. . . for the obese patient?

Because

Obedrin offers a practicable solution to the problem of keeping an obese patient on a restricted diet.

Because

Thousands of enthusiastic physicians have found that Obedrin curbs the appetite without making the patient jittery and does not cause insomnia.

Because

Obedrin contains enough vitamins to supplement the restricted diet. A large dose of vitamin C is included to help mobilize tissue fluids.

Because

Obedrin contains *Pento*barbital, a short-acting barbiturate, as a corrective. Pentobarbital has approximately the same duration of action as methamphetamine, so the possibility of cumulative barbiturate effect is negligible.

Available: The 60-10-70 Diet.* This is a convenient, variable diet, with enough roughage to eliminate necessity of artificial bulk laxatives.



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CYPRANE INHALER

for more effective analgesia



General practitioners value the ease of administration, the convenience and effectiveness of this potent analgesic — both in the office and on house calls. They find it especially well suited to obstetrics and minor operations. Patients appreciate the many advantages of Trimar, and are most co-operative in its administration.

Trimar — Ohio Chemical's brand of trichloroethylene, U.S.P., is manufactured according to highest standards, under rigid control • Colored for identification with certified dye • Non-explosive • Non-flammable • Contributes to uneventful recovery • Not unpleasant to take — no offensive odor • Post-anesthetic nausea is seldom encountered.

The Cyprane Inhaler is a compact, *complete* vaporizer unit which is simple to operate and permits self-administration under the physician's supervision.

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(Divisions or Subsidiaries of Air Reduction Company, Inc.)

Through the Menstrual Years of Life . . .

THE frequency with which the menstrual life of so many women is marred by functional aberrations that pass the borderline of physiologic limits, emphasizes the importance of an effective uterine tonic and regulator in the practicing physician's armamentarium.

In ERGOAPIOL (Smith) with SAVIN the action of all the alkaloids of ergot (prepared by hydro-alcoholic extraction) is synergistically enhanced by the presence of apiol and oil of savin. Its sustained tonic action on the uterus provides welcome relief by helping to induce local hyperemia, stimulating smooth, rhythmic uterine contractions and serving as a potent hemostatic agent to control excessive bleeding.

May we send you a copy of the booklet "Menstrual Disorders", available with our compliments to physicians on request.

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150 LAFAYETTE STREET, NEW YORK 13, N. Y.



IN ANY ALLERGY

'Co-Pyronil' *

affords

more profound,

more prolonged

relief with

fewer side-effects

than any other

known

antihistaminic.



Lilly

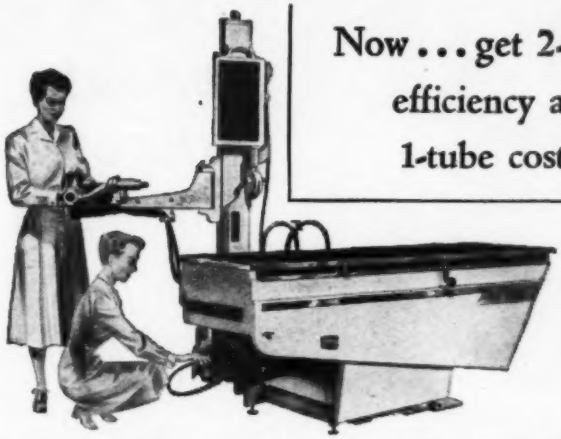
*'Co-Pyronil' (Pyrrobutamine Compound, Lilly)

Dosage

Mild symptoms: 1 pulvule every twelve hours.

Moderate symptoms: 1 pulvule every eight hours.

Severe symptoms: 2 pulvules every eight hours.



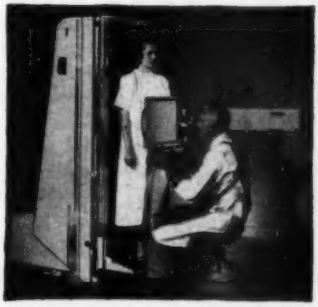
Now . . . get 2-tube efficiency at 1-tube cost

Maxicon ASC provides over-and-under the table tube positioning easily, compactly, economically

For complete reliability and flexibility — in both radiography and fluoroscopy — General Electric's Maxicon ASC is the outstanding unit in its class. Nowhere can you match its high-quality performance at so reasonable a price.

Conversion from radiography to fluoroscopy takes a matter of seconds. Complete straight-line tube positioning—with perfect counterbalancing — permits instant vertical movement of the tube from one focal distance to another . . . up to 40 inches. And the table-mounted tube stand angulates with the table for up to 40-inch vertical Bucky radiography. For operation with either 100 or 200 ma generators, Maxicon ASC is extremely compact — a valuable asset where space is limited.

Find out how Maxicon ASC's remarkable flexibility can serve you. Call your GE x-ray representative, or write X-Ray Department, General Electric Company, Milwaukee 1, Wis., for Pub. C-6.



Maxicon ASC lets you fluoroscope readily with the table in any position. With one hand you can operate shutter controls and position the easy-to-move screen.

You can put your confidence in —

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the **BROAD SPECTRUM** *vitamin* **B** *complex supplement*

MEJALIN

For more complete effectiveness in vitamin B complex supplementation, Mejalin supplies *all eleven of the identified B vitamins* in well balanced amounts. *Liver* is added for its contribution of other B vitamins. *Iron* is included since B complex-deficient diets are often iron-deficient also.

This broad spectrum supplement is useful in such conditions as childhood anorexia, stress periods, e.g., adolescence and pregnancy, prolonged antibiotic therapy, restricted diets, convalescence and liver disease, and in many other instances where vitamin B complex deficiency is present or may develop.

Mejalin is supplied in two exceptionally pleasant dosage forms: Liquid—infants and children like the appetizing candy-like flavor; Capsules—usually preferred by adolescents and adults.

Each teaspoon (5 cc.) of Mejalin Liquid and each Mejalin Capsule supplies:

Thiamine hydrochloride	1 mg.
Riboflavin	1 mg.
Niacinamide	10 mg.
Pyridoxine hydrochloride	0.2 mg.
Pantothenic acid*	1 mg.
Choline	50 mg.
Inositol	20 mg.
Vitamin B_{12} (crystalline)	0.33 mcg.
Folic acid	0.2 mg.
Biotin	0.02 mg.
Para-aminobenzoic acid	0.5 mg.
Liver fraction*	300 mg.
Iron*	7.5 mg.

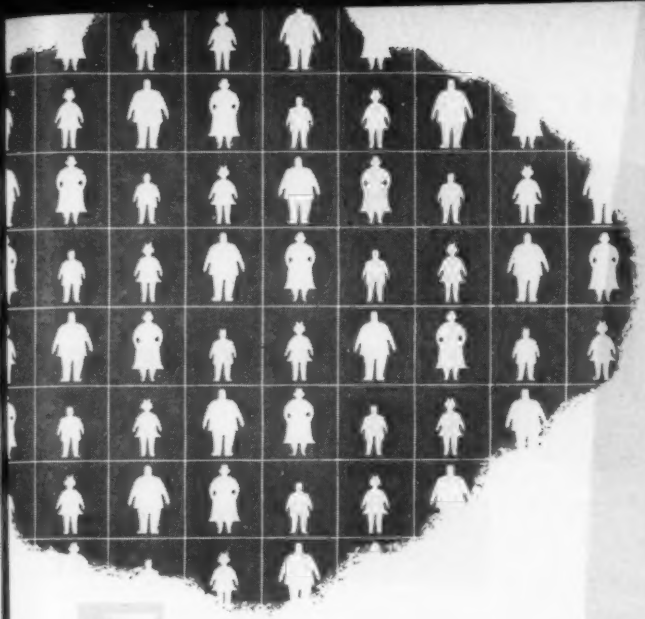
*Mejalin Liquid contains panthenol and soluble liver fraction N.F.; Mejalin Capsules contain calcium pantothenate and desiccated liver N.F. The 7.5 mg. of elemental iron is provided by ferrous sulfate.



MEJALIN

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will be grateful for CITRUS this year . . .

A 4-oz. glass of orange or grapefruit juice half an hour before lunch and dinner can materially reduce the demand for high-caloric foods, and enable the obese to adhere to their dietary regimens more satisfactorily. Citrus is particularly appealing because it is a "natural", non-medicinal, appetite-appeaser.

Other advantages of citrus, as an anoretic agent, are its readily utilizable carbohydrates (approximately 10-15 gm. per glass) which combat hypoglycemia—its almost universal availability—its popular flavor—and its economy.

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FLORIDA *Citrus*

ORANGES • GRAPEFRUIT • TANGERINES



THE FIRST QUADRI-SULFA MIXTURE



FOUR FOR GREATER TOLERANCE

DELTAMIDE

Composition

Each Tablet or each Teaspoonful (5 cc.) Chocolate-flavored Suspension of Deltamide contains:

1. **Sulfadiazine**.....0.167 Gm.
2. **Sulfamerazine**.....0.167 Gm.
3. **Sulfamethazine**.....0.056 Gm.
4. **Sulfacetamide**.....0.111 Gm.

Each tablet or teaspoonful (5 cc.) of suspension provides 0.5 Gm. of total sulfonamides.

Supplied: Deltamide tablets, in bottles of 100; Deltamide Suspension, in 4 oz. and 16 oz. bottles.

Indicated: In infections due to Group A hemolytic streptococci, staphylococci, pneumococci, meningococci, gonococci, and other microorganisms responsive to sulfonamides.

References: 1. Lehr, D.: Brit. M. J. 2:543-548, 1948. 2. Lehr, D.: Brit. M. J. 2:601, 1950. 3. Hawking, F., and Lawrence, J. S.: The Sulfonamides, New York, Grune and Stratton, 1951.

Deltamide—A Quadruple Sulfonamide Tablet and Suspension—represents the latest development in multiple sulfonamide therapy. Deltamide utilizes the fact that an increase in the number of sulfonamides in sulfonamide mixtures provides the significant advantages of greater clinical safety with lowered incidence of toxic and allergic reactions.[1,2]

The special formulation of Deltamide suspension eliminates the complaint of bitter aftertaste.

By combining four of the most useful sulfonamides,[3] Deltamide is superior on four counts:

- **Rapid initial absorption**
- **Effective blood levels**
- **High urinary solubility**
- **Very low toxicity**

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PHYSIOLOGIC THERAPEUTICS THROUGH RESEARCH

Letters

Commission on Health Needs • The great Rx conspiracy • Insurance payment methods • Controversy brings patients • Analyze medical expense? • Blames dentists • Professional courtesy • Private vs. government care

Magnuson Once More

SIRS: I must protest the statement, in your recent editorial on the Magnuson Report, that "most of the recommendations are sound." There can be but one classification for this report: Socialist buncombe.

A. G. Blazey, M.D.
Washington, Ind.

For the record, here's how the MEDICAL ECONOMICS *editorial statement to which Dr. Blazey objects appeared in context:*

". . . most of the [Magnuson Commission's] recommendations are sound. From a doctor's viewpoint, we'd estimate that fifty-four of them are likely to prove wholly acceptable; twenty-seven perhaps acceptable with reservations or in part; and only ten probably not acceptable at all.

"But statistics don't tell the whole story here, any more than they do in the fine art of cooking. We're reminded of the chef who does nicely with the soup, salad, rolls, and French fries—and then messes up the steak. For the main course served up by the Magnuson Commission seems to us a dubious mixed grill . . ."

Doctor-Druggist Scandal

SIRS: My compliments to the author of "The Great Rx Scandal" for a most impartial and unbiased presentation.

Of more than 400 New York physicians allegedly involved in this supposedly unethical doctor-druggist tie-up, I was the only one whose name was printed in the newspapers. So I'd like to tell my side of the story.

It's true that, along with a few other Negro physicians, I contributed certain funds in 1946 to assist in the establishment of a small interracial drugstore, the Provident Pharmacy. It was my hope that I would be helping build a modern pharmacy that would provide greater service to the members of my race. At that time, my colleagues and I were totally unaware that it would be considered unethical for a



Sinusitis Pain



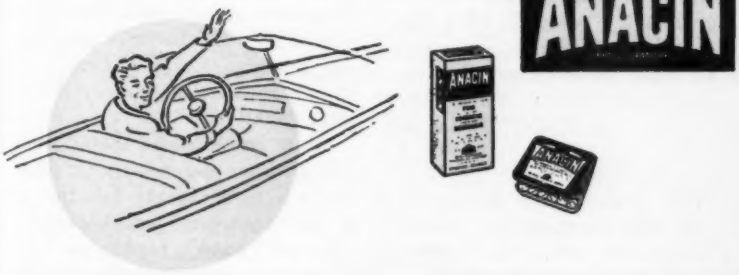


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For patients suffering pain and discomfort of chronic sinusitis, consider Anacin for fast, effective, long-lasting relief. The advantage of the APC formula, as provided by Anacin is that it may be taken safely over long periods of time, where continued use is indicated without the severe withdrawal characteristics of narcotics. Because of its availability at all pharmacies, ease of oral administration and economy, Anacin is one of the most frequently used analgesics for the relief of pain. Remember Anacin in your practice. Samples on request.

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physician to own shares in a drugstore.

On May 26, 1952, the Kings County medical society notified its members that it was inadvisable for a physician to have a financial interest in a drugstore to which he could send his prescriptions. At a subsequent meeting of the stockholders, we then unanimously voted to dissolve our corporation. The Provident Pharmacy was legally dissolved on August 18, 1952.

But on November 25 of last year, Attorney General Goldstein, acting as prosecutor, judge, and jury, decided that I was guilty and punished me by selecting my name—and mine alone—for public censure. After twenty-five years' practice without the slightest blemish on my character or name as a physician, I now find my reputation irrevocably damaged among my patients and medical associates.

I have requested the Kings County medical society to make a thorough and impartial investigation of my association with the Provident Pharmacy. I have also asked that I be given an opportunity to present my case before an impartial committee, in an effort to clear my name.

St. Elmo E. Taylor, M.D.
Brooklyn, N.Y.

SIRS: Some of the statements in your article suggest that the medical societies were at least partly to blame for not cleaning up the doctor-druggist conspiracy in New York.

I sat for three years on the New York County Board of Censors, and I never once saw them shirk their duty. But medical society officers are busy men; they have no time to sit around listening to gossip. I believe most of them were perfectly sincere when they claimed they knew nothing about this conspiracy.

Don't forget, too, that the medical societies don't have the money or the legal authority to conduct extensive investigations. And they can be sued if they proceed without sufficient evidence.

I agree with Attorney General Goldstein that the state should "make illegal much of what medicine now considers unethical." But let's not let the pendulum swing too far in that direction. Medicine and the law should work together on such problems.

William B. Rawls, M.D.
New York, N.Y.

SIRS: I think a doctor should have a perfect right to buy stock in a drug company, if he does so without fraudulent intent. And there's no reason why he shouldn't prescribe the products of such a company if they're reasonably priced and of high quality.

Your article states that doctors should leave the choice of a pharmacy to their patients. I do this, as a rule. But when I want a preparation that I know is hard to get, I see nothing wrong in my telling the patient where he can have his prescrip-

what you must know about

BUTAZOLIDIN®

(brand of phenylbutazone)

Accumulated experience in many thousands of cases has now proved conclusively that BUTAZOLIDIN produces therapeutic results in arthritis comparable to those obtainable with cortisone or ACTH. At the same time it has become equally evident that like other potent pharmacodynamic agents BUTAZOLIDIN can cause toxic as well as therapeutic response. In general, the drug has been found to produce minor reactions in a considerable percentage of cases and serious reactions in a few. To a considerable extent such reactions are preventable by proper precautions, and when not preventable are often readily controllable. For this reason physicians are urged to familiarize themselves thoroughly with the properties and proper usage of this potent new agent before prescribing it.

not a simple analgesic

The striking clinical benefits of BUTAZOLIDIN in arthritis and allied disorders cannot be due solely to analgesic effect since it has only moderate analgesic effect in non-rheumatic disorders.

an effective and potent anti-arthritic

BUTAZOLIDIN produces both improvement of function and relief of pain. In rheumatoid arthritis a recent report[1] indicates "major improvement" in 40 of 68 cases. Another notes "marked decrease in swelling, increase in range of motion, and increase in strength" in 41 per cent of patients with lesser improvement in an additional nine per cent.[2] A third study[3] records "appreciable pain relief" in 69 per cent of patients with 50 per cent showing objective evidence of improvement. Similar favorable results have been recorded in gout, spondylitis, osteoarthritis, bursitis, and other painful musculoskeletal disorders. These findings illustrate that BUTAZOLIDIN when properly used provides gratifying therapeutic benefit in a wide variety of painful and disabling disorders.

(1) Kunell, W. C., and Schaffarzick, R. W.: California Med. 77:319, 1952. (2) Stephens, C. A. L., Jr., and others: J.A.M.A. 150:1084 (Nov. 15) 1952. (3) Steinbrocker, O., and others: J.A.M.A. 150:1087 (Nov. 15) 1952.



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Now available in both 30 cc and 60 cc bottles, supplying 6 and 12 teaspoonfuls respectively.

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Dramcillin-250 with Triple Sulfonamides

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(100,000 units penicillin* and 0.5 Gm. sulfas† per teaspoonful)

Dramcillin (100,000 units* per teaspoonful)

Dropcillin (50,000 units per dropperful—0.75 cc.)

**Crystalline penicillin G potassium*

†0.167 Gm. each of sulfadiazine, sulfamerazine and sulfacetamide

White Laboratories, Inc., Kenilworth, N. J.

tion filled properly. After all, I'm responsible for seeing that he gets the proper medication. I expect to continue this practice.

M.D., New York

California Health Plan

SIRS: Neither the "old-style" service-type plan of the California Physicians' Service nor their new indemnity plan (as described in a recent issue of MEDICAL ECONOMICS) will obviate the inherent defects in this and other such insurance plans. The basic defect is that the one who benefits from the payments—the doctor—is in a position that permits him, to a great degree, to determine the loss. The built-in incentive to abuse can break the back of any health insurance plan.

The alternative, as I see it, is a direct agreement between patient and physician that for a set annual premium the doctor will furnish all necessary services. Call this "capitation" if you will; but it's the only practical way to provide medical service on a prepaid basis.

Russel V. Lee, M.D.
Palo Alto, Calif.

SIRS: Nothing appearing in MEDICAL ECONOMICS recently has disturbed me so much as the proposed California average-fee plan described in your April issue. Here, it seems to me, is a scheme that will lead to converting practice into an over-the-counter trade. It will also depress the doctor's income; and it will invalidate the unique feature that justifies medical society "service" plans.

Obviously, any so-called average-fee schedule is bound to publicize minimum charges. Yet the layman is equally bound to consider them as *maximums*. So, under the California plan, the doctor who tries to charge more than the depressing "average" will find himself on the carpet. And the burden of proof will rest on him. After all, why should anybody pay $100 for a tonsillectomy when it says right there in the book that the "average" fee is $35?

Medical services aren't packaged items, to be sold at so much apiece. Or is this a quaint, old-fashioned idea nowadays?

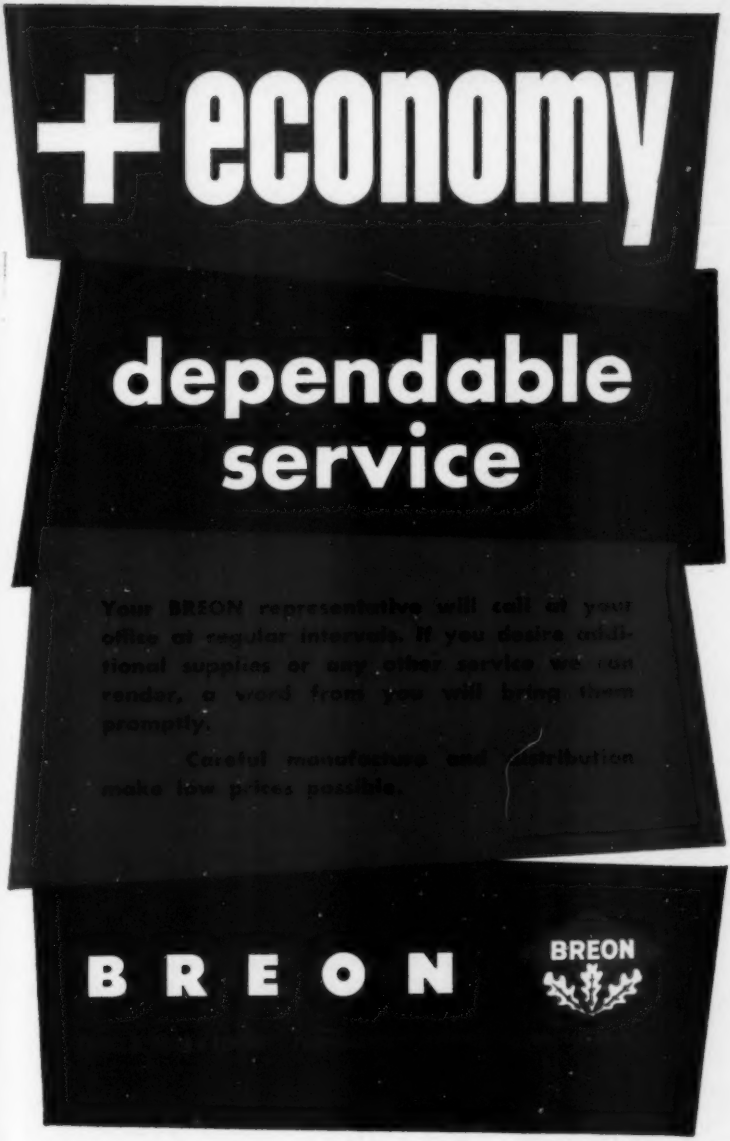
Must we yield to a plan that puts every kind of medical service into a neatly price-tagged package? Is our slogan to be "One price, no haggling"? If so, I expect the schedule will allow $5 for a night call, with an extra $1.50 an hour if the doctor sits up with a sick child, plus 75 cents if he worries.

Daniel J. Miller, M.D.
Washington, D.C.

Helps Business

SIRS: Here's an amazing bit of logic recently expressed by a colleague of mine:

"We doctors are ingrates not to appreciate what the advocates of socialized medicine did for our prosperity. These people informed the public that their health was being


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neglected because they didn't get adequate medical care. Then the newspapers played up the shortage of physicians. Immediately the sick, the near-sick, and the neurotic flocked to our offices. Then, when the furor over socialized medicine died down, our business dropped off. Maybe we doctors should revive the socialization boom so that we can again pay the rent!"

William E. Pentz, M.D.
St. Joseph, Mo.

Comparative Costs

SIRS: In the past ten years the cost of medical care has jumped so high that the average patient often finds it difficult, if not impossible, to pay. This rise in cost seems to have come about largely because of discoveries in medicine that have resulted in expensive new methods of diagnosis and treatment.

Thus, although great progress has been made in medical investigation, no comparable gain has developed in medical economics. The medical literature teems with articles suggesting new methods of diagnosis and treatment. But seldom is the author's enthusiasm for his method tempered by a thorough check of its results against results of other methods—and of relative costs.

Some doctors will say that cost is unimportant. This is perfectly true when the new methods are essential for saving a life. In treating the average case, though, the doctor often flounders in the sea of innumerable tests and types of management. He is little concerned about the relative monetary cost of these procedures—partly, perhaps, because he doesn't have to pay the patient's bills, but chiefly because he is ignorant of the relative costs of actual benefits.

A thorough analysis of comparative costs of alternative procedures would be interesting and of potentially great value to mankind. Would it be possible for such an analysis to be made?

D. J. Winslow, Major, M.C.
Mill Valley, Calif.

Dental Emergencies

SIRS: No one would deny that there should be closer understanding between doctors and dentists. As a general practitioner, I'm occasionally consulted by dentists concerning the dental aspects of diet, general body disease, and anesthetic risk; and of course I'm glad to cooperate.

But why is it that my most frequent contact with dental problems seems to come on week-ends, holidays, and at night? At such times, dental emergencies apparently turn into medical emergencies: The abscessed tooth is best treated with penicillin, the toothache requires an M.D.'s prescription, and the socket is still bleeding because of "poor clotting mechanism."

In my opinion, it's time the dentists again assumed full responsibility for their patients—not just by appointment between the hours of 9

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Available: 7 and 14 oz. Bottles

Samples? Of course, on your request!

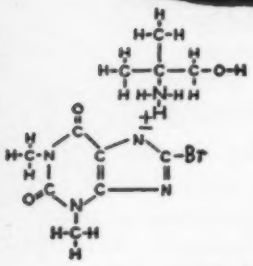
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81.66 PERCENT relief of premenstrual and menstrual distress

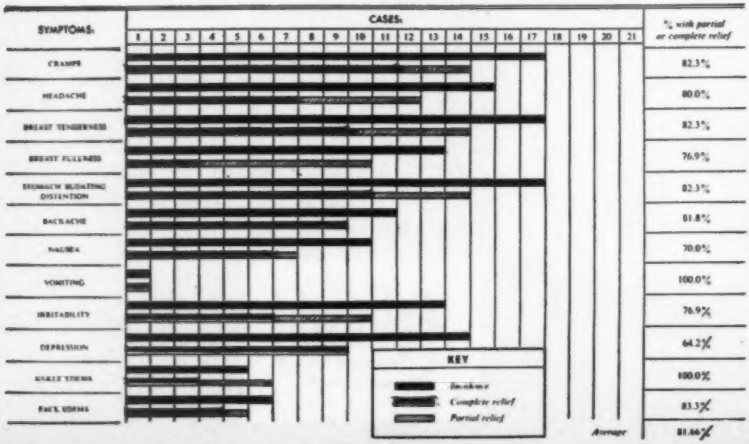
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FORMULA: each tablet contains:
2-amino-2-methyl-propanol-8-bromo-theophyllinate (pamabrom) ..... 50 mg.
Acetophenetidin ..... 100 mg.

Bottles of 24 and 100 tablets

INCIDENCE OF SYMPTOMS AND EFFECTIVENESS OF M-MINUS-5



A NEW development in the therapy of premenstrual tension and dysmenorrhea, M-Minus 5 is rapidly becoming the treatment of choice for these conditions.

Vainder* has recently reported that M-Minus 5 gave 81.66 percent relief in a study of 42 women with pronounced symptoms of premenstrual and menstrual distress (see chart). M-Minus 5 was equally reliable in controlling physical and mental complaints. In the great majority of cases, symptoms disappeared completely. The accompanying chart shows the symptoms usually most annoying to the patient—cramps, headache, breast tenderness and stomach bloating—were the ones that responded best to M-Minus 5.

M-Minus 5 affords more than mere symptomatic relief. Acting directly upon the factors which cause abnormal water retention, it promptly relieves the debilitating symptoms of the premenstrual period. In this same manner, M-Minus 5 prevents abnormal uterine and adnexal engorgement which often produces painful dysmenorrhea.

Optimal amounts of acetophenetidin provide "non-doping" analgesia to complete the therapeutic potential of M-Minus 5.

*Vainder, M.: Ind. Med., Vol. 22, No. 4 (April) 1953.

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—for simplified, one-treatment relief of joint and muscle pain. Combined action of rubefaction, analgesia and vasodilation brings prompt and long-lasting relief from the symptoms of sprains, lumbago, synovitis, bursitis, sciatica and arthritis.

(methacholine chloride 0.25%, thymol 1%, menthol 10%, and methyl salicylate 15%.)

and 5, but whenever these patients require attention.

Louis E. Braile, M.D.
Seattle, Wash.

Fees for Colleagues

SIRS: I emphatically disagree with the thesis behind the article, "Doctors Should *Pay* for Medical Care!" I've never accepted a fee from another doctor, or from a dentist or a nurse. No fee could have repaid me half so much as their whole-hearted appreciation and friendship.

Isaac Walton said, "He who fishes all day and only catches fish is no fisherman." So I say, "He who practices medicine all day and only makes money is no doctor."

Oliver R. Bryant, M.D.
Cross Lake, Minn.

SIRS: Not long ago, I was a patient in a hospital delivery room when a purely mechanical failure occurred. I overheard a nurse say, "Nothing *ever* goes smoothly when it's a doctor's wife!" This attitude seems to be universal among medical personnel.

When a doctor treats a member of a colleague's family, he's constantly on guard. This means that it just isn't possible to attain the ideal patient-doctor relationship.

I can't agree that payment of a fee would solve this problem. There just isn't any pat solution.

M.D.'s Wife, California

SIRS: The doctors I know welcome any opportunity to treat other M.D.s and their families. The time we spend with another physician or his family is often a pleasant rest period [*sic*] in a busy day.

L. H. Clemmons, M.D.
Cullman, Ala.

SIRS: It's my opinion that if we doctors can afford to *pay* for medical care, we can also afford to *give* it to our brethren.

William R. Bunge, M.D.
Laurel, Md.

Public Health Men

SIRS: I'm delighted to say that in more than twenty years of public health service I've never experienced such difficulties as those discussed by the author of "A Health Officer Talks Back."

When I was appointed county commissioner of health, the first thing I did was to talk over the public health program with every active physician in the county. That way, they all heard my views and I learned theirs. Then I applied for membership in the local medical society; and I regularly attended its meetings. As a result, my relationship with men in private practice has always been excellent.

I can't help feeling that the author probably overstepped the bounds of ethics in his chosen specialty—since he engaged, at least partially, in the practice of curative medicine. This may explain why he had some trouble with local practitioners.

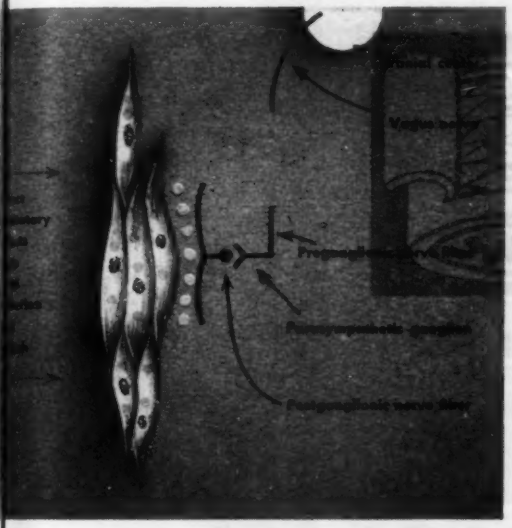
If he had *started* his career with the steps he outlines at the end of his article (doing only his pre-

PARASYMPATHOLYTIC ACTION

means dependable relief of

GASTRO-INTESTINAL SPASM

Homatropine methylbromide is parasympatho*lytic* (therefore spasmo*lytic*) in *all* therapeutic dosages. Since many drugs are parasympatho*mimetic* in customary dosages and parasympatho*lytic* only in high dosages attended by disturbing side effects, homatropine methylbromide is preferred for dependable relief of gastro-intestinal spasm.



In Lusyn the spasmolytic efficacy of homatropine methylbromide is reinforced by phenobarbital to allay emotional tension. The alukalin present provides welcome antacid-adsorbent efficiency.

Indicated in intestinal spasm, biliary spasm, pylorospasm, cardiospasm, and irritable colon.

PARASYMPATHETIC BLOCKING AGENT

Homatropine methylbromide relieves gastro-intestinal spasm by preventing the action of acetylcholine on smooth muscle cells.

EACH TABLET CONTAINS:

Homatropine methylbromide	5 mg. (increased from 2.5 mg.)
Alukalin (activated kaolin)	300 mg.
Phenobarbital	15 mg. (increased from 8 mg.)

SUPPLIED: Bottles of 100, 500, and 1000 tablets.

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scribed job; keeping local physicians informed of every health department decision that might affect them; trying to preserve the relationship between clinic patients and private physicians) he would doubtless have encountered less opposition.

Guy G. Lunsford, M.D.
Brookhaven, Ga.

SIRS: I believe that both private medicine and public health must share the blame for their mutual distrust. To avoid misunderstandings, individual doctors should assume such responsibilities as the care of charity patients, the aged, and the chronically ill. If we relegate these jobs to public health, we're virtually *inviting* government to enter the practice of medicine.

On the other hand, the public health men must recognize the necessity of gaining the confidence of the medical profession. For example, they should broach no new idea to the community before it has been explained to—and accepted by—local physicians.

What we need is more liaison (and less suspicion) between these two vital branches of the science of medicine.

James Z. Appel, M.D.
Lancaster, Pa.

SIRS: As a doctor and as a citizen, the private practitioner is anxious to have the assistance of public

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Synergistic salicylization of natural sodium glycocholate and sodium taurocholate accounts for the greater efficiency of Cholegestin as a choleretic and cholagogue. Thousands of physicians are prescribing Cholegestin with complete satisfaction in cases of gallbladder disease, catarrhal jaundice, intestinal indigestion and atonic constipation. Dosage 1 tablespoonful in cold water p.c.

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- 6 servings of macaroni and cheese, or
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- 12 pats of butter, or
- 8 boiled eggs, or
- 6 baked potatoes, or
- 9½ slices of bread

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The patient who insists on devouring his food in a hurry often pays the penalty of upset stomach for his speed with the knife and fork. BiSoDol, the dependable antacid, provides fast relief from stomach upset due to excess acidity by efficiently neutralizing the excess gastric juices that cause upset. And BiSoDol provides long-lasting relief, is pleasant tasting—well tolerated. Whenever your patients require really fast relief from acid indigestion, suggest BiSoDol Mints, Powder or *NEW* BiSoDol Chlorophyll Mints.

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tablets or powder



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health authorities in preventing disease and maintaining community health at a high level. But he can't help suspecting the motives of government authorities in health matters.

For years, doctors have heard men in high political office advocate the belief that an ever-increasing amount of the work of caring for the sick should be in the hands of government. And private practitioners have noted, too, the constantly expanding activities of the public health service.

So, while granting that the health of the *community* is the responsibility of the county health officer, the private practitioner must continue to insist that the care and treatment of *individuals* is his job, and his alone.

Thomas A. McGoldrick, M.D.
Brooklyn, N.Y.

SINS: Unlike your pseudonymous author, I feel there should be a definite demarcation between public and private medicine. When he says that "public health men must take a hand whenever greater financial or technical resources are required," he is obviously condoning the idea that public health men are free to move into almost every field, as long as government can collect enough tax money to pay for their activities. Whether he meant it that way or not, this amounts to advocacy of socialized medicine.

William W. Haggart, M.D.
Denver, Colo.

No "Belladonna BACKFIRE"



with this prompt, positive relief of FUNCTIONAL G.I. SPASM

More and more published clinical studies continue to prove that BENTYL provides effective relief from pain, cramps and general discomfort due to functional G. I. spasm . . . without "belladonna backfire."



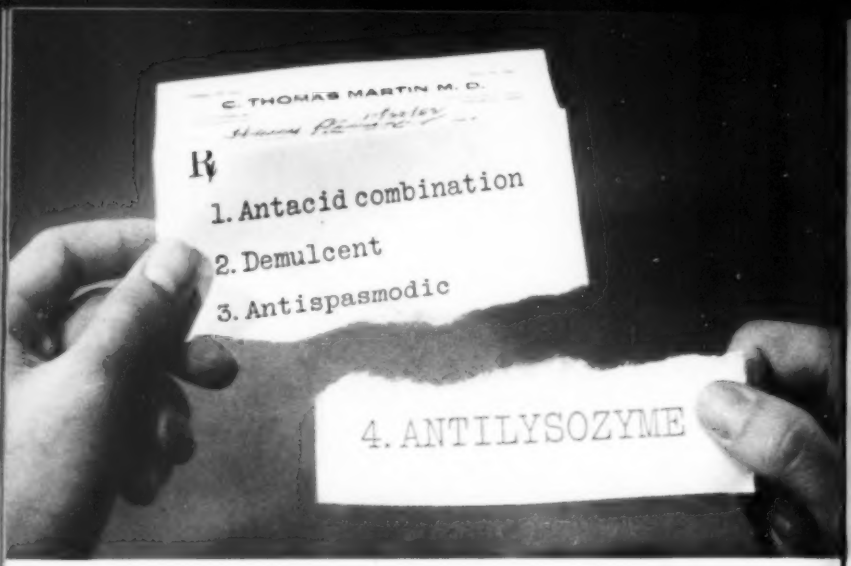
Trade-mark "Bentyl" Hydrochloride

℞ BENTYL

SAFE, DOUBLE-SPASMOLYSIS

Each capsule or teaspoonful syrup contains
BENTYL.....10 mg.
when sedation is desired
BENTYL.....10 mg.
WITH PHENOBARBITAL.....15 mg.

DOSAGE: *Adults*—2 capsules or 2 teaspoonfuls syrup 3 times daily, before or after meals. If necessary repeat dose at bedtime.
In Infant Colic—½ to 1 teaspoonful syrup 3 times daily before feeding.



Isn't this too often the missing fourth
in peptic ulcer therapy?

KOLANTYL INCLUDES THE IMPORTANT 4th FACTOR

1. **A SUPERIOR ANTACID COMBINATION** (magnesium oxide and aluminum hydroxide, also a specific antipeptic).
2. **A SUPERIOR DEMULCENT** (methylcellulose, a synthetic mucin).
3. **A SUPERIOR ANTISPASMODIC** (BENTYL Hydrochloride) which provides direct smooth muscle and parasympathetic depressant qualities without "belladonna backfire."
4. **INACTIVATION OF LYSOZYME**—Laboratory research and clinical studies[1,2] indicate that lysozyme plays an important role as one of the etiologic agents of peptic ulcer. By inhibiting or inactivating lysozyme with sodium lauryl sulfate, KOLANTYL includes the important 4th factor toward more complete control of peptic ulcer.

KOLANTYL

DOSAGE: 2 Kolantyl tablets or 2 to 4 teaspoonfuls of Kolantyl Gel every 3 hours as needed for relief.

1. Hufford, A. R., Rev. of Gastroenterology, 18:588, 1951
2. Miller, B. N., J. So. Carolina M. A., 48:1, 1952

TRADE-MARKS "KOLANTYL," "BENTYL"



a *penetrant* emulsion for chronic constipation

KONDREMUL® (PLAIN)

COLLOIDAL EMULSION OF MINERAL OIL AND IRISH MOSS

permeates the hard, stubborn stool of chronic constipation with millions of microscopic oil droplets, each encased in a film of Irish moss... makes it more movable



KONDREMUL PATCH

KONDREMUL *(Plain)*—Pleasant-tasting and non-habit-forming. Contains 55% mineral oil. Supplied in bottles of 1 pt.

KONDREMUL *(With Cascara)*—0.66 Gm. nonbitter Ext. Cascara per tablespoon. Bottles of 14 fl.oz.

KONDREMUL *(With Phenolphthalein)*—0.13 Gm. phenolphthalein (2.2 gr.) per tablespoon. Bottles of 1 pt.

When taken as directed before retiring, KONDREMUL does not interfere with absorption of essential nutrients.

THE E. L. PATCH CO. — STONEHAM, MASSACHUSETTS

Recommended recipes for feeding baby



1. Human Breast Milk: "the recipe of the most satisfactory food for a baby."

Gunther, M.: Brit. J. Nutrition 6 (No. 2): 215, 1952.

2. SIMILAC®

so similar to the milk of healthy, well-nourished mothers that there is no closer equivalent.

Similac in the baby's stomach forms a soft, fine, fluid curd assuring rapid and easy digestion. Close equivalence (in quantity and quality of nutrients) to breast milk promotes good growth and reduced incidence of complications during the first year of life.

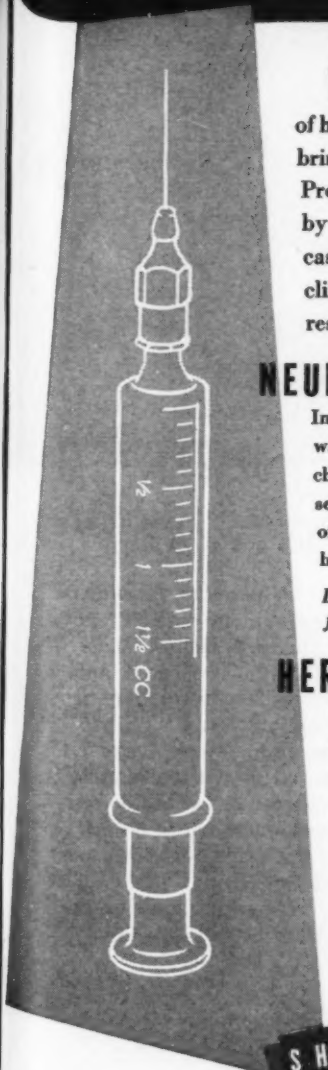
Similac is simple to prepare

Supplied: Similac Powder in tins of 1 lb., with measuring cup; Similac Liquid in tins of 13 fl. oz.

M & R Laboratories, Columbus 16, Ohio

PROTAMIDE

FOR THE PATIENT SEEKING RELIEF FROM NERVE ROOT PAIN



WHEN the disturbing and painful symptoms of herpes zoster, or the stinging distress of neuritis brings the patient to you, quick relief is expected. Protamide helps solve this therapeutic problem by providing prompt and lasting relief in most cases. This has been established by published clinical studies, and on the valid test of patient-response to Protamide therapy in daily practice.

NEURITIS (Sciatic—Intercostal—Facial)

In a recent study* of 104 patients, complete relief was obtained in 80.7% with Protamide. 49 were discharged as cured after 5 days of therapy with no subsequent relapse. (Without Protamide, the usual course of the type of neuritis in this series has been found to be three weeks to over two months.)

Dosage: one 1.3 cc. ampul intramuscularly, daily for five to ten days.

HERPES ZOSTER

A study* of fifty patients with Protamide therapy resulted in excellent or satisfactory response in 78%. (No patient who made a satisfactory recovery suffered from postherpetic neuralgia.) Thirty-one cases of herpes zoster were treated with Protamide in another study.* Good to excellent results were obtained in 28.

Dosage: one 1.3 cc. ampul intramuscularly, daily for one to four or more days.

** A folio of reprints of these studies will be sent on request.*

SHERMAN LABORATORIES
BIOLOGICALS • PHARMACEUTICALS
WINDSOR DETROIT 19, MICH. LOS ANGELES

XUM



The Physician's Antacid . . . Why?

When a physician needs an antacid, what is his personal choice?

We know, from daily contact with thousands of physicians from coast to coast, that a great number use Gelusil personally and for their families. Our professional service records show that many doctors have used it for years for hyperacidity and related gastrointestinal disturbances.

Why?

They can have their pick of antacids, yet they use Gelusil. A physician, like his patients, demands effectiveness without side effects.

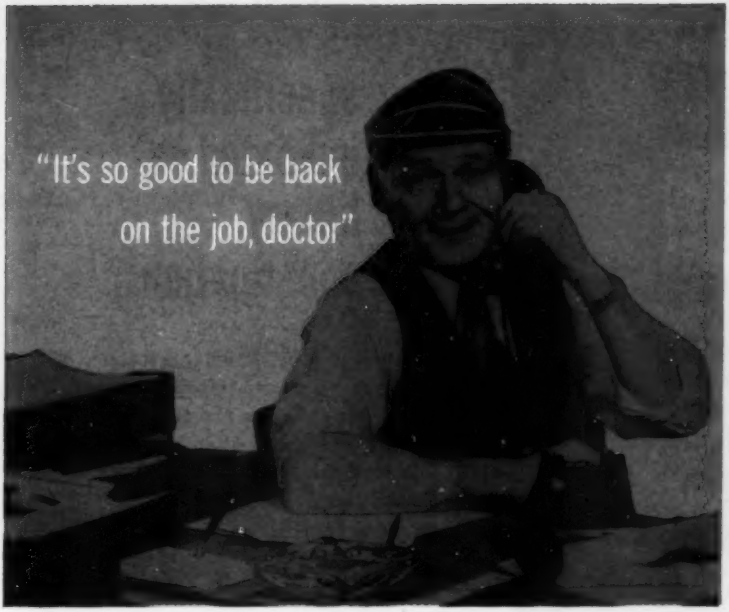
He gets this with Gelusil — fast, lasting relief from each dose, and no trouble with constipation or other aberrations, even with prolonged use. Its palatable flavor is refreshing and always acceptable.

An ever-larger group of doctors and their patients agree on Gelusil. Each year the usage of Gelusil increases substantially.

WARNER-CHILCOTT LABORATORIES
Division of Warner-Hudnut, Inc.,
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Prescribe *Gelusil*® **WARNER**

THE PERSONAL ANTACID OF MANY PHYSICIANS BY PERSONAL PREFERENCE



TABLET

NEOHYDRIN®

BRAND OF CHLORMERODRIN

NORMAL OUTPUT OF SODIUM AND WATER



PRESCRIBE NEOHYDRIN whenever there is retention of sodium and water except in acute nephritis and intractable oliguric states. You can balance the output of salt and water against a more physiologic intake by individualizing dosage. From one to six tablets a day, as needed.

PRESCRIBE NEOHYDRIN in bottles of 50 tablets. There are 18.3 mg. of 3-chloromercuri-2-methoxy-propylurea in each tablet.

Leadership in diuretic research

Lakeside LABORATORIES, INC., MILWAUKEE 1, WISCONSIN

1 choleretic

2 digestant

3 laxative

specifically indicated in biliary constipation

Constipation is usually associated with biliary stasis and impaired digestion. Tablets of Caroid and Bile Salts with Phenolphthalein offer 3-way help in the reestablishment of normal function in these cases.

CHOLERETIC ACTION
- Stimulating bile flow for easier fat digestion

DIGESTANT ACTION
- The enzyme, "Caroid," promotes protein digestion

LAXATIVE ACTION
- With minimal laxative dosage

Supplied: bottles of 20, 50, 100, 500, and 1,000.

Write for a trial supply today!

American Ferment Co., Inc.
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Caroid® and Bile Salts TABLETS

specifically indicated in biliary dyspepsia and constipation

NEW

Superior Analgesic Combination

TRYADS

TRADE MARK

WAMPOLE

FORMULA

Each tablet contains:
(1) Salicylamide . . 225 mg. (3½ gr.)
(2) dl-Desoxyephedrine hydrochloride . . 2 mg. (1/30 gr.)
(3) Acetophenetidin . 150 mg. (2½ gr.)

Superior—Safe Analgesia without Opiates

SALICYLAMIDE possesses an antirheumatic, analgesic effect hardly approached by other salicylic acid compounds—7.5 times the analgetic potency of aspirin.

The absence of any significant untoward effects upon the kidneys, blood or internal organs, when fed to laboratory animals over long periods of time, places SALICYLAMIDE alongside aspirin as a safe analgesic. Unlike other salicylates, salicylamide does not increase prothrombin time. Therefore, TRYADS are safe to use after tonsillectomy and tooth extraction.

Smoother—More Efficient Action

By combining analgesics of different classes of drugs, a smoother, more efficient analgesic action is achieved. The addition of acetophenetidin, a complementary analgesic, is supported by clinical use.

Relief from Pain-induced Psychic Depression and Fatigue

dl-DESOXYEPHEDRINE improves psychic and psychomotor function. The small oral dosage employed in TRYADS Tablets relieves the pain-inflicted depression and fatigue.

INDICATIONS: Myalgia, arthralgia, neuralgia, simple headache, migraine, dysmenorrhea, postoperative pain following minor surgery, malaise and fever associated with the common cold and similar disorders.

Dose: 1 to 2 tablets every 2 to 4 hours as required.

Supplied: Tablets, scored; bottles of 100 & 500.

WAMPOLE LABORATORIES

HENRY K. WAMPOLE & CO., INCORPORATED • PHILADELPHIA 23, PA.

Clinical Evaluation of Pro-Banthīne*

CASE REPORT

"M. D., female, aged 48, had a posterior gastrojejunostomy 14 years ago for duodenal ulcer. The patient was fairly well until nine months ago when severe, intractable pains occurred. She was hospitalized and a subtotal gastrectomy was done.

"She remained well for only a few months and was referred to us because of recurrence of very severe pain and marked

*Trademark of G. D. Searle & Co.



Fig. 1: "Roentgen examination . . . revealed the ulcer to be very much in evidence."

Fig. 2: In ten weeks "the ulcer niche was no longer in evidence roentgenologically or gastroscopically."



weight loss. Roentgen study revealed a fairly large ulcer niche on the gastric side of the anastomosis.

"The patient had been on various types of antacids and sedatives without relief from pain. She was given 60 mg. of Pro-Banthine q.i.d. and within 72 hours was able to sleep through the night for the first time in weeks.

"At the end of two weeks of such treatment the patient had absolutely no pain and felt that she had been 'cured.' Roentgen examination at this time revealed the ulcer to be very much in evidence (Fig. 1). Much persuasion was necessary to make the patient realize the importance of maintaining her diet and therapy.

"Ten weeks of controlled regulation was necessary before we were satisfied that the ulcer niche was no longer in evidence roentgenologically or gastroscopically (Fig. 2).

"She has been maintained on 30 mg. of Pro-Banthine for almost five months with no recurrence of symptoms."

Schwartz, I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: A Clinical Evaluation of a New Anticholinergic Drug, Pro-Banthine, to be published.

Pro-Banthine (*brand of propantheline bromide*), the new, improved anticholinergic agent, is more potent and, consequently, a smaller dosage is required and side effects are greatly reduced or absent.

Peptic ulcer, gastritis, intestinal hypermotility, pancreatitis, genitourinary spasm and hyperhidrosis respond effectively to Pro-Banthine, orally, combined with dietary regulation and mental relaxation.

NEWS ABOUT A BAUER & BLACK PRODUCT

Which elastic bandage lets you control the pressure?

The bandage on the left is TENSOR—woven with live rubber threads

You, doctor—not the *bandage*—control the pressure when you use a Tensor Elastic Bandage.

You apply *low* pressure as easily as high pressure.

You obtain *uniform* pressure over the entire bandaged area.

You apply pressure with substantially *less* danger of hyperconstriction of the blood vessels. And with substantially *greater* mobility for your patient.

Moreover, you do not have to adjust Tensor as swelling goes up and down—it adjusts *itself*.

The picture tells why Tensor does so much for you in the treatment of vascular and muscular disorders. As you see, it is more than *twice* as elastic as old-style bandages. It is woven with *live rubber threads*—not just cotton.

Isn't that the kind of elastic bandage, Doctor, that you want *your* patients to wear?

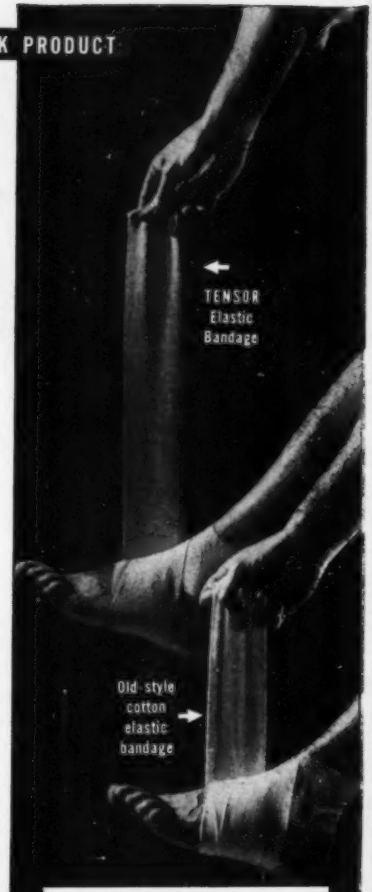
TENSOR®

ELASTIC BANDAGE

Woven with live rubber threads

BAUER & BLACK

Division of The Kendall Co.
309 West Jackson Blvd., Chicago 6, Ill.



Under equal tension,
Tensor stretches approximately twice as far as old-style cotton bandages. And Tensor will snap back smoothly to its original length. That's why Tensor gives you greater control of pressure, reduces constriction, increases your patient's mobility.

from the research laboratories of the world's largest producer of antibiotics . . .



a new antibiotic

of special value

Magnamycin®

brand of carbomycin

Clinically active particularly against those infections caused by penicillin-resistant gram-positive pathogens—staphylococci, streptococci, and other enteric organisms.

Cross-resistance with penicillin, streptomycin and the broad-spectrum antibiotics has not been observed.

Well tolerated.

Magnamycin is not inactivated by the gastric secretions.

Available in the most familiar, readily accepted dosage form—sugar coated tablets.

Recommended dosage—1.0 to 2.0 Gm. daily in divided doses.

Supplied:
100 mg. tablets, bottles of 25 and 100

Antibiotic Division Pfizer CHAS. PFIZER & CO., INC.
Brooklyn 6, N. Y.

Three years of testing further confirms

SKOLEX

SUN ALLERGY CREAM

Most complete protection against ultraviolet rays



Now, three years of testing by doctors further confirms the impenetrability of Skolex Sun Allergy Cream to wave lengths 2900-3200 A.U.—the region in the spectrum most responsible for sunburn and other skin reactions to ultraviolet rays.

Skolex has successfully protected even the most hypersensitive or sun-allergic skin from the damaging effects of these rays.

Skolex cream base is also helpful to dry skin conditions often associated with sun sensitivities.

ACTIVE INGREDIENT:

PROPYLENE GLYCOL PARA AMINO BENZOATE

BASE: Stearic Acid, Cetyl Alcohol, Petrolatum, Hydroxybenzoate, Triethanolamine, Carbowax, Perfume (non-irritant), Water.

Samples are available for your clinical use. Write Dept. ME-2. The J. B. Williams Company, Glastonbury, or use coupon below.

THE J. B. WILLIAMS COMPANY, (Dept. ME-2)
GLASTONBURY, CONN.

Please send me samples of Skolex for clinical use.

Name_____

Address_____

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"Look at your 'write' hand, Doctor!"

Does it ever occur to you that these trained fingers . . . sensitive to the faintest beat of a patient's pulse, skilled in the guiding of the surgical scalpel . . . are employed far, far too often to guide *a pen?*

There's a better way to keep ahead of the paper work—reports, diagnoses, post-operative notes, laboratory findings—so necessary to recording your medical practice. The AUDOGRAPH Electronic Soundwriter is changing medical record-keeping; for with AUDOGRAPH you simply speak your mind, and the facts are recorded accurately and clearly for subsequent transcription by your medical secretary or a staff typist.

Get the full facts, *today* . . . save time, eliminate laborious handwritten records and free yourself for other essentials of your busy practice. You'll save yourself money, too. Just use the coupon and discover the better way of streamlining your day.

Made by The Gray Manufacturing Company — established 1891 — originators of the Telephone Pay Station.



The "Master" Audograph: the ideal combination dictating and transcribing machine. Records on thin, lightweight, long-lasting plastic discs holding up to *one hour's dictation.* Will operate wherever electric current is available.

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AUDOGRAPH sales and service in 180 principal cities of the United States. See your Classified Telephone Directory. Canada: Northern Electric Company, Ltd., sole authorized agents for the Dominion. Overseas: Westrex Corporation (Western Electric Export Corporation) in 53 foreign countries.

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THE GRAY MANUFACTURING COMPANY, HARTFORD 1, CONNECTICUT

Send me Booklet AK-6—"Saving The Doctor's Time."

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Prelude to asthma?

not necessarily . . .

Tedral, taken at first sign of attack, often forestalls severe symptoms.

in 15 minutes...Tedral brings symptomatic relief with a definite increase in vital capacity. Breathing becomes easier as Tedral relaxes smooth muscle, reduces tissue edema, provides mild sedation.

for 4 full hours...Tedral maintains more normal respiration for a sustained period—not just a momentary pause in the attack.

Prompt and prolonged relief with Tedral can be initiated any time, day or night, whenever needed, without fear of incapacitating side effects.

Tedral provides:

theophylline	2 gr.
ephedrine	⅜ gr.
phenobarbital	⅛ gr.

in boxes of 24, 120 and 1000 tablets

Tedral

WARNER-CHILCOTT
Laboratories NEW YORK

Questions

Collecting in accident cases • Loans for internes • Reading matter for waiting patients • How to survive moving day • A regular savings plan

Accident Cases

A few days ago, I treated a man who had been injured in an automobile accident; but I later misplaced his name and address. Since I know the name of the driver who was responsible for the accident, should I send the bill to him?

Not unless you have proof that the driver promised to pay the cost. Otherwise, as always, the patient (or the patient's family) is legally responsible for the medical bill. This holds true even if he was unconscious when you were called to attend him, and was therefore unable to give his consent to treatment.

If, as in this instance, you can't identify the patient, police and highway authorities should be able to help you; they doubtless have records of the accident. (You should, by the way, have gone to them anyhow, with your report as attending physician.)

In any auto-crash case, collection may present a special problem, since the patient usually is a stranger. So always be sure to get necessary details as soon as you can.

And don't overlook the possibility that you may be called to testify in court. It's always wise to keep careful records of accident cases, with details about the nature of the injury, treatment given, and your advice to the patient.

One last word of advice: When you do learn the patient's name and address, bill him immediately. In such cases it's unwise to wait till the end of the month, since he may be insured—and your bill should be on hand when he files his claim.

Loans

I've signed up for a residency in ophthalmology next year, and I need money to take care of my family until I enter practice. Unfortunately, I have no personal property that I can use as collateral for a bank loan; and none of my friends or relatives can help me. Do you know of any organizations that make loans to internes?

Neither the American Bankers Association, nor the American Foundations Information Service, nor any one of a variety of other sources

central nervous "pacifier"..



A. H. ROBINS CO., INC. · RICHMOND 20, VA.

Ethical Pharmaceuticals of Merit since 1878



Robins

In Mephate 'Robins', the clinical usefulness of mephenesin per os has been significantly heightened by the inclusion of glutamic acid hydrochloride, which improves absorption and enhances effectiveness for many patients otherwise unresponsive.* Provides a relaxant effect on skeletal muscle spasm; an ameliorating effect on tremor; and a relief of anxiety without dimming consciousness. Particularly helpful in abnormal neuro-muscular conditions such as rheumatic disorders, disc syndromes and cerebral palsy; alcoholism, anxiety tension states and psychiatric states.

In each Mephate Capsule, 0.25 Gm. mephenesin — with 0.30 Gm. glutamic acid hydrochloride. Adult dosage starts at 2 capsules 3 or 4 times a day, preferably with food or liquids.

*Hermann, L. F., and Smith, R. T.: Jl. Lancet 71:271 (July), 1951.

If Your Patients Can't Tolerate
NICOTINE
TRY John Alden CIGARETTES

Nicotine Actually Bred Out Of The Leaf
John Alden cigarettes are made from a completely new, low-nicotine variety of tobacco. A comprehensive series of smoke tests*, completed in 1951 by Stillwell and Gladding, one of the country's leading independent laboratories, disclose the smoke of John Alden cigarettes contains:

At Least 75% Less Nicotine Than 2 Leading Denicotinized Brands Tested
At Least 85% Less Nicotine than 4 Leading Popular Brands Tested
At Least 85% Less Nicotine Than 2 Leading Filter-Tip Brands Tested



Importance To Doctors And Patients
John Alden cigarettes offer a far more satisfactory solution to the problem of minimizing a cigarette smoker's nicotine intake than has ever been available before, short of a complete cessation of smoking. They provide the doctor with a means for reducing to a marked degree the amount of nicotine absorbed by the patient without imposing on the patient the strain of breaking a pleasurable habit.

ABOUT THE NEW TOBACCO IN JOHN ALDEN CIGARETTES
John Alden cigarettes are made from a *completely new variety of tobacco*. This variety was developed after 15 years of research by the Kentucky Agricultural Experiment Station. Because of its extremely low nicotine content, it has been given a separate classification, 31-V, by the U. S. Dept. of Agriculture.



*A summary of test results available on request.

Also available:
Low-nicotine John Alden cigars and pipe tobacco.

John Alden Tobacco Company
22 W. 43rd St., N.Y. 36, N.Y. Dept. E-8
Send me free samples of John Alden Cigarettes
Name_____ M. D.
Address_____
City_____ Zone____ State_____

FREE PROFESSIONAL SAMPLE

queried can answer this question.

It's true that banks often make personal loans without collateral. But no bank is likely to give a sizable loan to a resident who is earning a very limited income and who, in a year or so, will have to go much deeper into debt to set up a practice.

As for the foundations, they apparently award fellowships or grants only to men who plan to go into teaching or research.

Any suggestions from readers?

Moving

Last time I moved my office, the cost in money and wasted time was—well, I'd rather forget it. Now I'm about to move again, and I wonder whether there's some better way to do it. Can you give me any suggestions?

First of all, choose a reputable moving concern whose men are bonded. Cut-rate companies, as you may have found, are poor economy. Make certain, too, that your property is insured—either by you or by the moving company—against damage in transit. Such insurance policies are quite inexpensive, and are well worth the money.

Try to do most of the packing yourself—well in advance. Before the movers arrive, rugs should have been rolled and tied; framed diplomas and pictures stacked in newspaper sandwiches; books fitted into substantial wooden cases; cabinets and desk drawers emptied of equip-

Knox Gelatine proven effective in the treatment of Refractory Anemias

Recent investigation shows[1] hemoglobin concentration and red blood cell count increased in every case, with high statistical significance, in refractory anemia patients plateaued to iron and getting a good diet.

Gelatine is a good hematopoietic protein because it contains 70 per cent of blood-building amino acids, according to criteria of Whipple and Robscheit-Robbins.[2]

Gelatine contains 25 per cent of glycine, an amino acid used in the synthesis both of the hemin[3] and the globin[4] portion of hemoglobin, and is utilized directly for these purposes.[5]

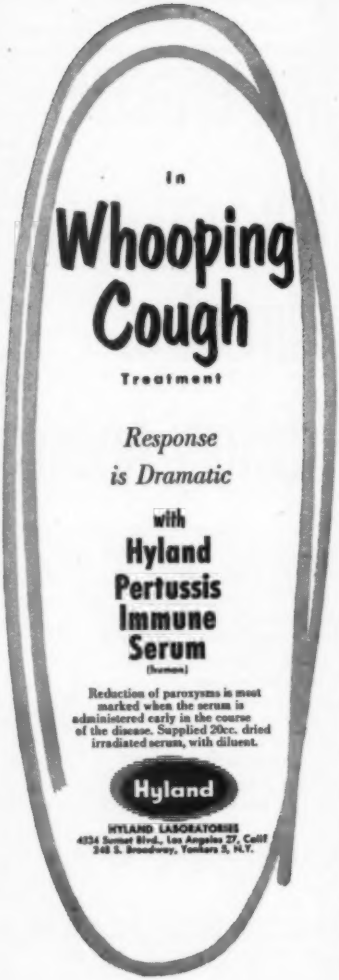


AVAILABLE AT GROCERY STORES IN 4-ENVELOPE FAMILY SIZE AND 32-ENVELOPE ECONOMY SIZE PACKAGES.

An envelope of Knox Gelatine taken in water, or a favorite fruit juice, milk, or other beverage, two to four times a day according to need, will furnish an abundance of hemin and globin building amino acids and lead to better utilization of iron. Large doses are necessary by the law of mass action, in order that the amino acids will be used directly, before deamination or synthesis into other body proteins.

Knox Gelatine U.S.P. • All Protein • No Sugar

1. Reich, C., and Mullnos, M. G., Treatment of Refractory Nutritional Anemia with Gelatine. Bull. N. Y. Med. Coll. March 1953.
2. Whipple, G.H., and Robscheit-Robbins, F.S.: Amino Acids and Hemoglobin Production in Anemia, J. Exper. Med. 71:569, 1940.
3. Shemin, D., and Rittenberg, D.: Utilization of Glycine for the Synthesis of the Porphyrin, J. Biol. Chem. 159:567, 1945; The Biological Utilization of Glycine for the Synthesis of the Protoporphyrin of Hemoglobin, J. Biol. Chem. 166:621, 1946.
4. Grinstein, M., Kamen, M., and Moore, C.V.: The Utilization of Glycine in the Biosynthesis of Hemoglobin, J. Biol. Chem. 179:359, 1949.
5. Graff, J., and Hoverman, H.D.: On the Metabolism of Beta-Alanine, J. Biol. Chem. 186:369, 1950.



ment. You can leave linen and other soft goods in drawers, *if tightly packed;* but make sure you lock, tape, or tie all such drawers shut.

It's also a good idea to make a sketch of the floor plan of your new quarters and to mark each room on it with a distinctive color. Then you can tag every bulky piece of equipment or furniture with a corresponding color, and the movers will know where to set things down. That way, you'll avoid a lot of confusion.

Above all, keep a record of what goes into each packing case or barrel. Then, if you urgently need to find something, you can do so without tearing everything apart. Less essential items may be unpacked more or less at your leisure.

Reading Matter

I'm about to open my first office for the practice of pediatrics, and I'd appreciate your suggestions on reading matter for the waiting room.

Among the juvenile magazines that librarians recommend are Story Parade, Children's Digest, and Junior Natural History (published by the American Museum of Natural History in New York). Very small children prefer picture books, of course. But be sure to get the durable kind, printed on cloth.

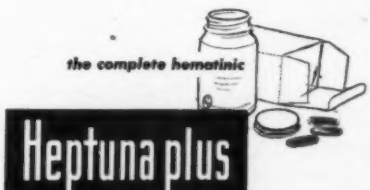
You'll also want to include something of interest to mothers: for instance, Parents' Magazine and the Ladies' Home Journal, as well as



MEASURE A HEMATINIC BY ITS RESULTS

Because of the close correlation between normal hemopoiesis and adequate nutrition, many cases of anemia fail to show complete recovery despite hemopoietic stimulation, until all nutritional deficiencies are corrected.

HEPTUNA PLUS accelerates the clinical response to anemia therapy because it supplies ALL the Vitamins, Minerals and Trace Elements required for erythrocyte and hemoglobin formation.



Each Capsule Contains:

FERROUS SULFATE U. S. P.	4.5 gr.
VITAMIN B12	5.0 mcg.
FOLIC ACID	0.33 mg.
ASCORBIC ACID	50.0 mg.
COBALT	0.1 mg.
COPPER	1 mg.
MOLYBDENUM	0.2 mg.
CALCIUM	37.4 mg.
IODINE	0.05 mg.
MANGANESE	0.833 mg.
MAGNESIUM	2 mg.
PHOSPHORUS	29.0 mg.
POTASSIUM	1.7 mg.
ZINC	0.4 mg.
VITAMIN A	5,000 U. S. P. units
VITAMIN D	500 U. S. P. units
THIAMINE HYDROCHLORIDE	2 mg.
RIBOFLAVIN	2 mg.
PYRIDOXINE HYDROCHLORIDE	0.1 mg.
NIACINAMIDE	10 mg.
CALCIUM PANTOTHENATE	0.33 mg.
With other B-Complex Factors from Liver	

J. B. ROERIG AND COMPANY, CHICAGO 11, ILLINOIS

some of the picture magazines like Life and Look.

Other possibilities for both children and adults: cartoon books, humor anthologies, and volumes containing reproductions of famous paintings.

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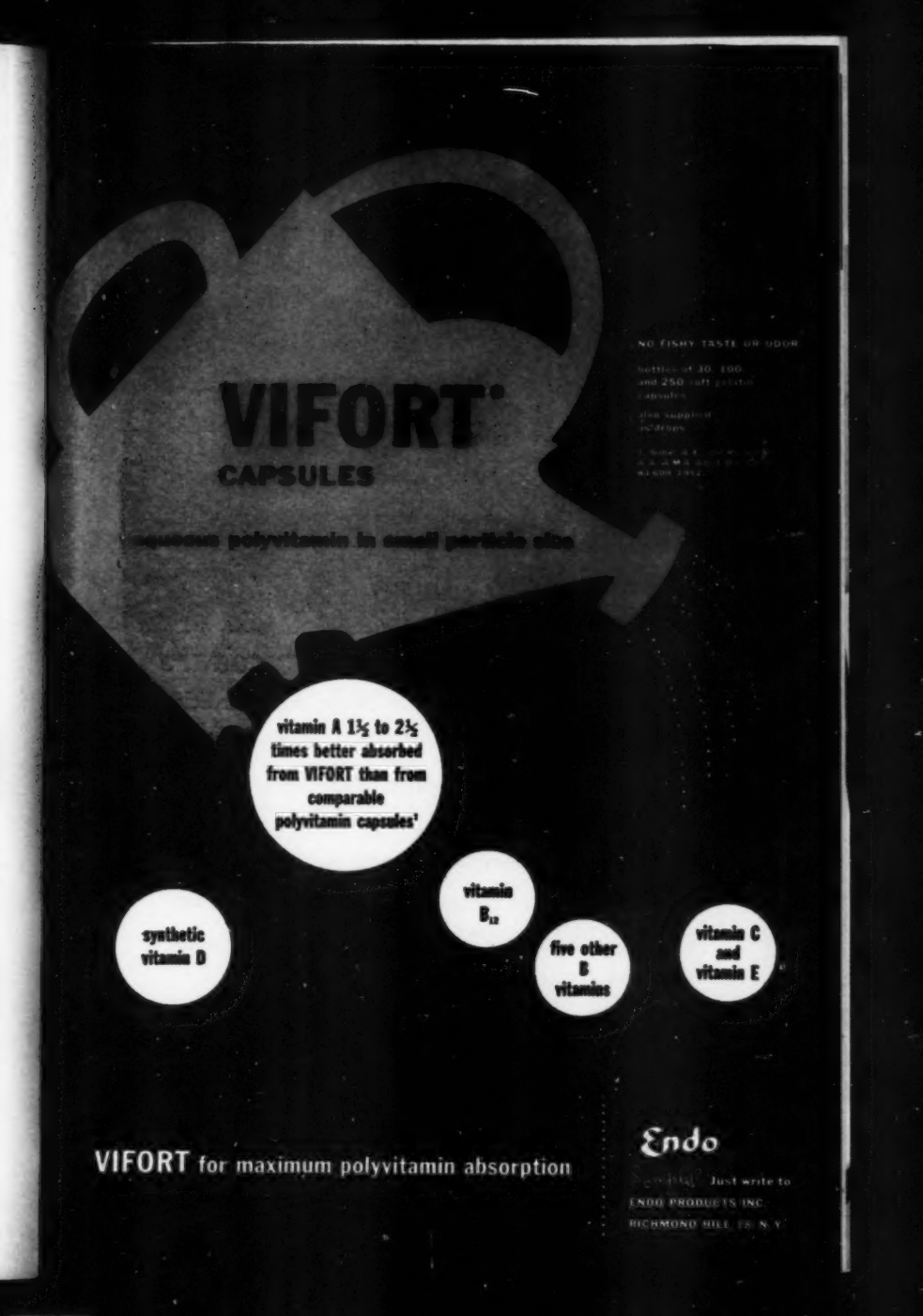
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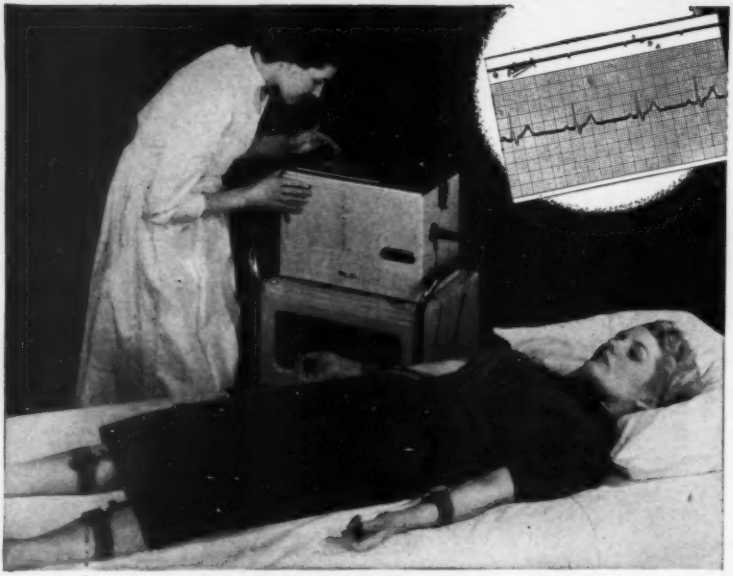
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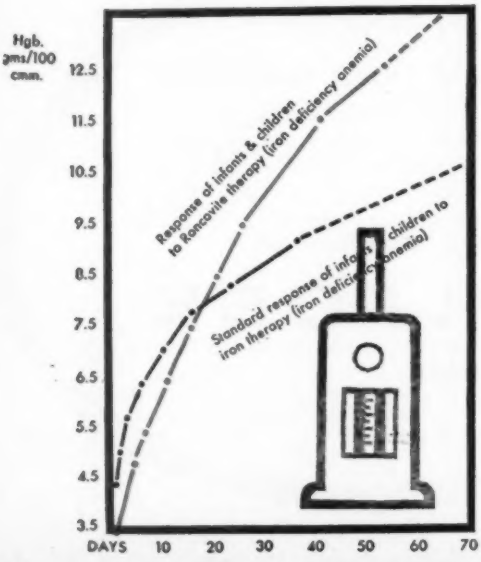
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Standard response chart Josephs, H. J. Pediat. 49:246 (1931).

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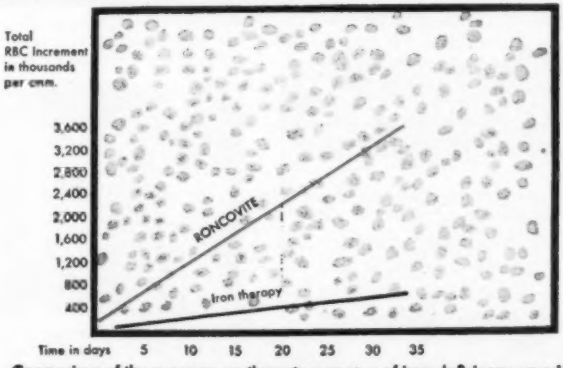
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Supplied in bottles of 15 cc. with calibrated dropper.

1: Wolff, H.: Med. Monatsschr. 5:239 (1951); (2) Rohn, R.J., and Bond, W.H.: to be published; (3) Berk, W., et al: New England J.M. 240:754 (May) 1949: (4) Robinson, J.C., et al: New England J.M. 240:749 (May) 1949; (5) Weissbecker, W., and Maurer, R.: Klin. Woch. 24:855 (1947); (6) Wolff, H., and Barthel, S.: Munch. M. Wschr. 93:467 (1951); (7) Gardner, F.H.: J. Lab. & Clin. M. 41:56 (Jan.) 1953.

*The pioneer cobalt product; a product of Lloyd Research.



Comparison of the average erythrocyte response of iron-deficiency anemic children to Roncovite[2] and to iron therapy.—Computation—Method of Schiodt: Am. J. Med. Sci. 193:313 (1937).

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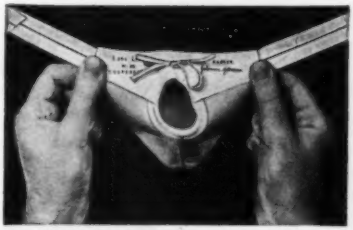
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Further details about the Siemens-Reiniger equipment are available — for example:

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(This equipment will be on exhibit at the Seventh International Congress of Radiology in Copenhagen.)

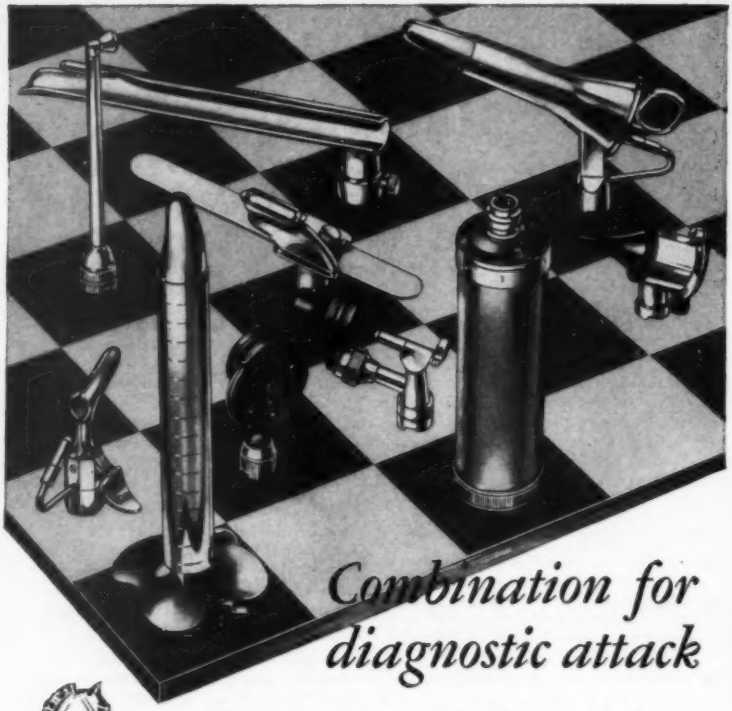
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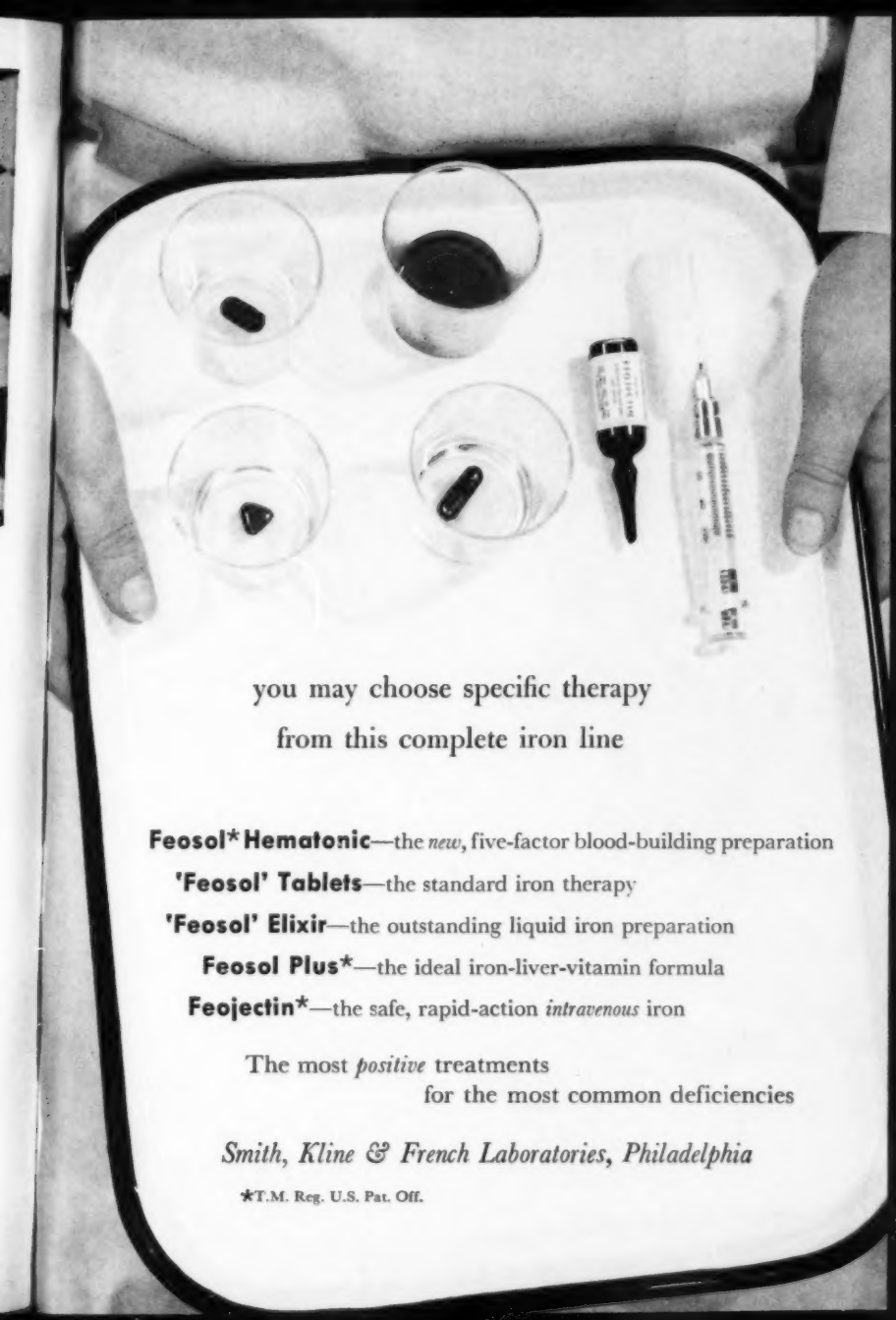


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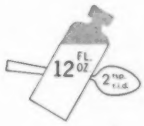
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Medical Economics
JUNE 1953 · VOLUME 30 · NUMBER 9

Editorial

Meet the Critics

● "You can hardly pick up a magazine these days," said a colleague of ours, "without finding at least one article on doctors. And you know what that article's always called?"

"Tell us," we said.

" 'Doctors Are Crooks!' " he snorted. "Or, 'From Hippocrates to Hypocrisy.' "

We laughed, as we were supposed to. Our friend often exaggerates for effect; and he had done so this time.

But behind his remark, we realized, was a fact to be reckoned with:

There *is* widespread criticism of medical men today. Laymen *do* seem to distrust physicians. Many lay writers accuse doctors of having become halo-wearing dollar-worshipers. Others tend to generalize about the "false" standards of the profession.

Sure. We know this is an unwarranted generalization. We know it's the fee gougers, the ghost surgeons, and the cash-pocketing tax evaders in our midst who give us a bad name. We know that the hardened wrongdoers are only a small minority, and that of the men practicing medicine today the overwhelming majority not merely live by the code of ethics—they swear by it.

We know this. The trick is to convince the *public.*

Not long ago a national magazine ripped into the profession for what it called "the average doctor's excessive materialism." Shortly afterwards, at a public meeting, a medical society officer was asked to answer the charge. [MORE→

He tried, but didn't do too well. What he did was to pin scarlet letters on the minority of obvious miscreants, and it just didn't go over. The point is that if we publicly heap *all* the blame on the unscrupulous few, people may well conclude that we're sacrificing a scapegoat to spare our own hides.

A little self-examination might better come first. Let every one of us ask himself whether any of *his* activities may be subject to misinterpretation. It's just possible that the public thinks that we're a materialistic lot because *we give that impression.*

Take Dr. X, for example. He's president of his county medical society and a respected community leader. He contributes generously of his time to charity work; yet some people think he more than makes up for it by the size of the bills he sends to paying patients.

Or take Dr. Y. He has long been a key figure in the hospital of which he's chief of staff. Building that staff with an eye to ever higher standards is among his most cherished aims. So much so that many local doctors are denied hospital privileges and they charge that they're victims of a hospital-practice monopoly. Their patients, meanwhile, complain that the hospital's tightly closed staff tends to kite the cost of medical care; as a result, they maintain, "free choice of physician" becomes no more than an empty phrase.

Dr. Z is another. He's a general practitioner who's so wrapped up in the clinical side of his practice that he just "hasn't time" to worry about the financial and public relations sides. His typist takes care of collecting the accounts, setting some of the fees, and, as she puts it, "keeping the folks in line." She does it with such a vengeance that, while the doctor doesn't know it, he's a Shylock to his patients and a public relations delinquent.

These are just a few examples of a type of thoughtlessness that too many an honest physician is guilty of. Yet he's generally not conscious of it; so whenever criticism breaks out, he's likely to believe that some fringe practitioner must be to blame (if anyone is) and that he and the profession at large have been unfairly maligned.

It goes without saying that medical men can stack their record for integrity and public service against that of any other occupational group. But it's not enough, we're learning, simply to be better than average. The public expects us—because of our custody of human life, perhaps—to set standards for the rest of society—almost to the extent that the ministry does.

Perhaps we can't hope to satisfy that expectation in full. But the individual doctor can, if he will, make two things abundantly clear to those who consult him:

¶ That money is not his obsession;

¶ That the welfare of his patients *is.*

—H. SHERIDAN BAKETEL, M.D.

You Can't Coax the Cat Down Till You Chase the Dog Away





How We Apportion Fees Ethically at Our Hospital

By A. Burgess Caldwell, M.D.

Here's a practical code in black and white that guides G.P.s and surgeons in prorating charges for bona fide services. Among other things, it has ended local confusion over 'fee splitting'



● At least one good thing has emerged from the fog of bewilderment created everywhere by the American College of Surgeons' crackdown on fee splitting: The doctors at my hospital now have a comprehensive code to guide them in the equitable and ethical apportionment of fees. And because the rules are down in black and white, in plain language, the fog locally has pretty well disappeared.

The code was put together, after long and earnest study, by a hospital staff committee of which I'm a member. We're satisfied that it doesn't conflict anywhere with the position of the A.C.S.—of which I'm also a member —insofar as that position has been made clear. Unfortu-

nately, the College's position in this matter has been more often clouded by thou-shalt-nots than illumined by constructive suggestions.

At any rate, the plan seems to be working well for the physicians and surgeons concerned, for their patients, and for our community. And this is important, I think, because the furor over fee splitting—however much good it may have accomplished in some places—has had the effect of confusing a great many doctors to whom "fee splitting" was a nasty word long before the latest outcry was raised in Chicago.

These doctors don't need lessons in ethical practice. But with the press echoing intemperate blasts about family doctors and surgeons allegedly sinning together, they do welcome a constructive approach to the fee problems that have arisen. Some of our most ethical men are

EDITOR'S NOTE: A. Burgess Caldwell is the pen name of an Eastern surgeon, a fellow of the American College of Surgeons, whose outspoken criticism of that organization recently attracted considerable attention. In a letter signed "M.D., New Jersey," printed in MEDICAL ECONOMICS for January, Caldwell said:

"For years, the A.C.S. was asleep at the switch. It spent most of its time and money on its hospital standardization program, letting the needs of the individual surgeon go hang . . . More and more, the A.C.S. . . . seems destined to become an exclusive 'club' . . . with little real potency."

Among the letters that came in response was a friendly request from Dr. Willard H. Parsons, chairman of the A.C.S. Board of Governors. "I have an idea that you could make some very valuable suggestions," Dr. Parsons wrote, "and I would like to present them to the Gover-

no longer sure how long they'll continue to *appear* ethical to their patients.

Pattern of Action

It's my hope that the guideposts we've set up in our community will help other doctors to find their way out of the woods. Or, at least, that the story of what we've done—and are doing—will suggest patterns of action suitable for other localities.

Our staff committee was handed a pretty big job. Its assignment was to chart an open and aboveboard method, completely ethical and in keeping with the patient's interests, whereby two or more doctors participating in a case might receive fair payment for their services *without fear of criticism.*

It took three months. The result was a guide or set of recommendations, touching on all aspects of the

nors. Your comment will be genuinely appreciated."

Says Caldwell: "Regarding my original criticism, there's this to be said for the College: Since divorcing the hospital program, it has already shown signs of waking up. It has started smaller meetings, and it's paying more attention to the needs of its members—both steps in the right direction.

"I hope the College will continue to decentralize its activities. It needs to get into the field, to get acquainted with the problems of practicing surgeons in the smaller communities and hospitals.

"Right now, for example, it could do a lot to help solve the local problem of ethical fee apportionment which its free-swinging crusade against unethical fee splitting has obscured."

This article tells how the doctors of Caldwell's own community tackled the problem *without* help.

•

subject we could think of. And it was distributed to our more than 100 staff members.

The Main Points

Four cardinal points are made in this guide. They're intended to dispose, once and for all, of any confusion between ethical fee apportionment and unethical fee splitting. Here's how our staff members translate them into action:

1. Fee divisions are considered justifiable only as they represent fair and proper payment of physicians and surgeons *for services actually performed.*

2. The total surgical fee in which a referring physician shares is never higher than the fee the surgeon would charge for a comparable procedure *not* involving a referral.

3. The total fee is established during a frank discussion of all pertinent details with the patient. This discussion takes place pre-operatively in elective procedures and as soon as feasible after emergency operations.

4. With a reasonable fee established, and a fair portion designated to each participating doctor, the patient is told to expect a corresponding—*and separate*—bill from each. If for any reason this arrangement has not previously been made clear to the patient, it's explained in a letter accompanying the surgeon's bill for his portion of the fee.

Our guide also outlines for the family doctor and the surgeon their proper roles and duties. It states, for example, that the initial fee discussion with the patient should almost always be the job of the G.P. Why? Because it's the family doctor who generally knows the patient's financial status best. Even if he doesn't, he's in a better position than the surgeon to arrive at a suitable figure through discussion.

"Your wife had an expensive stay in the hospital a few months ago," he may say. "This operation will undoubtedly cut your earning power for a little while, and of course there'll be other things to pay besides doctor bills. The surgeon and I feel that, under the circumstances, $300 would be a fair, though less than usual, fee for our combined services. Is that agreeable to you?"

If the patient has Blue Shield or other medical insurance, he's told whether or not it will pay the full fees of the surgeon, the G.P., and the anesthesiologist (it won't, as a rule, although generally it covers at least the greater part of the surgeon's fee).

Other Contingencies

Having established the fee, the G.P. makes certain that the patient understands he'll *not* be paying two doctors for the same service, but that the total fee will be apportioned to pay the doctors for their *separate and distinct services.* Furthermore, he emphasizes that the fee will cover everything, including post-operative care after [MORE ON 213]

Medical Veterans Organize

Though born only last December, their national association now has 20,000 members; it keeps a watchful eye on the doctor draft; and it has plans for future activities, too

By Mauri Edwards

● Outside of official circles, one of the busiest telephones in the nation's capital is the Republic-7 number of a young internist. "But, unfortunately for my family and me," says 33-year-old William B. Walsh, "more and more of my calls have nothing to do with my practice."

Instead, the jangling phone brings him a constant stream of complaints from colleagues and inquiries from Congressmen—mostly about the doctor draft. They call Dr. Walsh because he's the unofficial Washington representative of the nation's newest and fastest growing association of physicians: the Medical Veterans Society.

This organization started almost from scratch last December. Yet its membership by April was more than 20,000. And a good proportion of the members seem to know Bill Walsh's phone number, as I found out one day last month, when I spent an hour and a half in his office. The telephone kept interrupting our discussion of the M.V.S. with such demands as these:

¶ A doctor from a Midwestern city complained that the local selective service board was passing up an M.D. in Priority 1 without consulting the medical advisory committee. Walsh promised to look into the case.

¶ A physician from an Eastern city reported that a Priority 2 doctor—the assistant to a prominent surgeon—

was claiming exemption because he was "indispensable." Walsh said he'd check up.

¶ A Senator asked the young internist to cite "a few cases of injustices to veterans under the doctor draft." Walsh reeled off four.

There was also a call from a patient.

In between calls, Walsh told me how the M.V.S. had developed into an organization to reckon with—an organization that's fighting for "a better national draft law and more efficient operation of that law at the local level, where it really counts." But even more, said Walsh, "the M.V.S. is a youth movement in medicine." Then he added: "I guess I talk too much, but I can't help getting wound up about this thing."

A.M.A. Likes It

A lot of people get "wound up" about the association. Some accuse it of "pressure" tactics, but more are enthusiastic. A high-up official in military medical circles told me that the society "is a healthy thing—good for the military, and good for medicine, too." An A.M.A. leader said: "We like the society. There's absolutely no conflict between us."

Added this doctor: "Medical veterans have had a tough time. It's no wonder they've organized. Of course, we of the A.M.A. keep after the Pentagon ourselves; but the younger men believe they're closer to the situation.

"After all, it's *their* future at stake, not ours. So we understand their viewpoint, and we don't object."

The veterans welcome such expressions by the A.M.A. brass. But local medical societies, they charge, aren't always so cooperative. "They're generally run by nonveterans," Walsh explained to me. "And since the *real* draft problems occur at the local level, we veterans would be lost without the M.V.S."

History of M.V.S.

While the organization in its present form dates back only to last December, its actual beginnings were in 1946, when local associations grew up out of the needs of medical men returning from World War II. But as these doctors found their bearings as civilians, their interest in such activities naturally waned. By 1951, most of them were holding annual Pearl Harbor Day dinners—and letting it go at that.

When the Korean War broke out, a few societies of veterans offered tips to the Pentagon on how to draft doctors. But the medical veterans awakened to their full potentialities only last November. At that, it took shock treatment to stir them to action. The shock was this: With Priorities 1 and 2 almost used up, word got around that the Pentagon planned to pass up the older physicians in Priority 3 and, instead, call up only the doctors under 41, including veterans of World War II (those who thought themselves secure in Priority 4).

The reasoning behind such a move was obvious: Wouldn't it be more feasible to call back men who'd already served than to pluck established civilian physicians from their communities?

But when the veterans got wind of this, they exploded. The upshot: Doctor-veterans in Ohio, who were still maintaining an active organization, called a national meeting to decide on a national course of action.

Their Objectives

The meeting, held in Toledo, was a modest affair, with only about twenty states represented. But it started the M.V.S. on its way.

At their first get-together, the veterans decided on a course of action. And they drew up such basic objectives as these:

1. The M.V.S. would watch over the interests of physicians who'd already served their country.
2. At the same time, the society would help the armed forces get all necessary medical care for the troops.
3. And it would try to insure that those physicians who had not yet served their country weren't denied the privilege.

The M.V.S. elected Dr. Kenneth C. McCarthy, who already headed the Toledo association, as interim president—to serve until a national convention in New York in June. (McCarthy and Dr. Robert Green of Cincinnati, who was named vice president, had been largely respon-



M.V.S. SPARK PLUGS: Dr. Kenneth C. McCarthy, the first president [▲], and Dr. William B. Walsh, the society's Washington representative [▼].



sible for running the Toledo meeting.) Dr. Walsh was named Washington representative, to deal with Congress and the Pentagon.

Now that the M.V.S. was in business, doctor-veterans flocked to it. By March, there were 12,000 members, and there were chapters in most states. By mid-April, membership had soared to 20,000 and was still on the way up.

As the society grew, its leaders worked out a draft policy aimed at tapping the pool of Priority 3 physicians. The A.M.A. agreed substantially on all major particulars. And the Pentagon—under pressure—decided to lower its physical standards and keep the top draft age at 51.

It's a Watchdog

In other, less spectacular ways, the M.V.S. now performs additional services for its members. For one thing, local associations keep tabs on the rulings made by local draft boards.

In one Western city, for example, three Priority 1 doctors were deferred recently as essential to medical education. "You know why?" asks Walsh. "The three of them gave a *total* of a day and a half a week to the local medical school." Promptly, the M.V.S. hopped on the draft board; and the three young M.D.s are now in uniform.

In a Midwestern city, an industrial physician's two partners were about to be called up. But the older doctor said he couldn't handle his practice alone; so, on the recommendation of the local medical society, the draft board declared the young partners essential. Again, the local M.V.S. chapter stepped in. It told the public that with about eighty doctors in the area, there was no shortage of physicians. And, as a result, the medical society adopted a new policy: Henceforth, it announced, it would not regard *any* physician in the area as essential.

It Helps Cut Waste

The medical veterans have kept after the Pentagon, too, with Bill Walsh urging the armed forces "to see that the American soldier gets the *best* medical care, with the *least* waste of medical talent." To this end, Walsh bombards the military and Congress with true—and shocking—stories of such waste.

One of the more horrendous true tales: A service hospital was suffering from lack of patients. So signs were posted, encouraging officers to send in their dependents for check-ups.

When even this failed to keep the hospital census up to the required level, the hospital turnover was slowed down. According to one account, it then took forty-six days to run a hernia case in and out of the institution.

Does Its Work Pay Off?

It's a fact that since the M.V.S. has been policing the situation, the Pentagon has re- [MORE ON 195]



What Growth Stocks Offer You

The company that plows its profits back into research and development may offer its stockholders the prospect of low dividends but high appreciation—hence, a greater long-term return, taxable at capital-gains rates

By Raymond Trigger

● The following statement is condensed from a folder put out recently by a well-known publisher of investment advice:

"Anyone who hopes to make a fortune in securities in the years ahead should seriously consider buying 'growth stocks.' Such a fortune is within your grasp—and it can be realized within an astonishingly few years—IF you're astute enough to capitalize on what experts agree will be the most expansive period in our history. Carefully selected growth stocks can make you independently wealthy."

Many such extravagant claims appear today in the literature and newspaper advertising of firms dispensing

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RAYMOND TRIGGER *is the editor of Investor magazine. His references to specific companies in this article do not, of course, constitute an endorsement of those companies or of their stocks.*

investment "services." Any investment dealer or broker brash enough to echo these claims would probably find the eagle eye of the Securities & Exchange Commission on him. Yet they're not entirely false.

So let's examine some of the reasons why shrewd investors *do* recommend growth stocks. And we'd better begin with a definition:

A growth stock is an equity in a company that will probably grow faster than the economy as a whole. In most cases, the company operates in a youthful industry—one that's less stable and "leveled off" than, say, rails, tobacco, or foodstuffs. Examples often cited are Consolidated Engineering, Skiatron Electronic & Television Corp., Glass Fibers, Inc., National Petrochemical, Titanium Metals Co., Fedders-Quigan, etc.

But it's important to realize that not *all* growth companies are new and young. Because of continuing research and forward-looking management, some of the nation's great industrial enterprises are constantly being infused with exciting new growth prospects. A few illustrations:

¶ It was in A.T.&T.'s Bell Laboratories that the transistor, which may make vacuum tubes obsolete, was developed.

¶ Dow Chemical and Detroit Edison are working hand in hand to explore the production of electric power by atomic energy—as are Monsanto Chemical and Union Electric of Missouri.

¶ As many doctors know, the ethical drug companies now have some strange bedfellows; among the companies currently producing drugs are meat packers Wilson and Armour, distiller Schenley, Corn Products Refining, and many others.

¶ That venerable old company, American Type Founders, is now making, in addition to printers' type, such things as sound recorders, kitchen equipment, and office furniture.

Growth stocks, then, may be available from young companies on the way up or from old companies determined to stay young. Such companies may ordinarily be expected to expand well above the general average for industry, in both usefulness and profits.



Profits Into Research

A primary characteristic of growth stocks is that the companies issuing them tend to plow all or most of their earnings back into research and development.

Largely as a result of this policy, we're living today in what can be described without exaggeration as the most exciting industrial era in history. Thousands of physicists,

chemists, and research scientists of every type now work where only a handful worked a generation ago. Just think of some of the developments you've been reading about lately:

Magnesium from sea water . . . solar energy supplementing atomic energy . . . soy beans into paint . . . atomic bombardment replacing furnace treatment of iron . . . space travel . . . new catalysts to develop new wonder drugs . . . coal into shower curtains . . . electronics . . . titanium . . .

It takes money to develop these products and processes. Here, for instance, is a statement from a recent annual report of one great research-minded corporation:

"The du Pont Company of today is the result of the evolution of a typically small enterprise—established near Wilmington, Del., in 1802. The original investment in that enterprise amounted to $36,000. By the end of 1948 the total investment in the business had increased to $1,347 million. About 25 per cent of this growth has been achieved through the willingness of stockholders to invest their savings, and about 75 per cent *from amounts reinvested in the business.*"

There's an illuminating postscript to that statement in an issue of the du Pont stockholders' magazine. It says:

"Du Pont's research and development, which go on in good times or bad, tend to stabilize operations. The company estimates it takes from five to fifteen years to develop a major new product. Research in synthetic ammonia, for example, began in 1918; commercial operations started in 1926. It showed its greatest loss in 1929 at the peak of the boom, its first profit in 1932 in the bottom of the depression!"



It's a Slow Process

So it's well to remember that research has long-term value. It pays off financially tomorrow, not today. But that it *does* pay off is evident in such news items as the following condensed from the New York Times:

"Research has proved to be a valuable ally for Minnesota Mining and Manufacturing. It has enabled the company to expand its product line from sandpaper to more than 1,000 diversified items. Although this research has been costly, reaching close to $35,000,000, the company has realized $25 in sales for every research dollar invested. Products marketed last year as a result of this research accounted for 85 to 90 per cent of the company's $190,000,000 sales volume."

Another characteristic of growth

stocks is that they pay below-average dividends.



Small Current Yield

Low dividends in themselves don't, of course, constitute sure-fire proof of the growth factor. But when dividend dollars you might ordinarily receive are siphoned into research and development, the immediate yield on your investment is naturally small. Typical of the slim dividend pickings you get from growth stocks are the following approximate yields:

Dow Chemical	1.3%
Imperial Oil	2.5
Minnesota Mining	2.3
Owens-Corning Fibreglass	2.0
Union Carbide & Carbon	4.6
Int'l Business Machines	1.8
Hartford Fire	2.0
Thompson Products	3.8
Hercules Powder	4.5
Merck & Co.	4.0

Now let's take a look at some of the advantages of such stocks:

The primary advantage, of course, is that they offer a chance for unusual profits. It's not through accident or luck, for example, that a $10,000 investment in Eastman Kodak at the beginning of this century is worth about $450,000 today. Or that the stock of Minnesota Mining and Manufacturing is now selling at more than twenty-five times its price at the peak of the dizzy 1929 stock market!

But there are other advantages to growth stocks, too. For instance:

1. Since part of your earnings as a shareholder are retained and invested (primarily in research) by the company, the chances are that your money will work harder for you than it would otherwise.

2. In the long run, you're likely to profit by the soundest sort of compounding of interest.

3. Because of the low dividends, you'll save on income taxes.



Your Tax Is Lower

To enlarge a bit on this third advantage: Obviously, high dividends from any investment may put you in a higher tax bracket, since they swell your regular income. But if you buy stock in a company that uses its earnings for expansion, instead of distributing them, your annual tax load will be that much less.

Meanwhile, the growth stock itself should appreciate in value. And when you ultimately sell it, you'll be required to pay tax on only half your

profits, since you'll be able to report them as a long-term capital gain. By then, too, you may be closer to retirement and in a lower tax bracket.



'Don't Go Overboard'

All sounds pretty wonderful, doesn't it? Maybe so. But you'd better not rush right out to invest your money in growth stocks without further ado.

A couple of centuries ago, Alexander Pope said: "Be not the first by whom the new is tried, Nor yet the last to lay the old aside." He didn't have investors in mind when he wrote those words. But he might as well have had.

Not by a long shot will prosperity come to all firms "by whom the new is tried." Management is always the priceless ingredient; and sometimes it takes a little time for management to assert itself.

So don't leap at a company just because it's apparently young or enterprising. What if you *don't* get aboard on the ground floor? There's lots of room between the second or third story and the roof.

And don't buy a stock, put it away, and forget it. Growth is sometimes a mirage. You can think of countless products that were household names when you were a youngster, but that have given up to more alert competitors.

Even in the burgeoning chemical field, promise sometimes doesn't mature. Not many years ago, for instance, Air Reduction was regarded as a company with a brilliant future. It may still have a future; but it's no favorite of investment counselors today.

So take a price licking if you must. But "be not the last to lay the old aside." When the Dow-Jones industrial average was originated in 1896, it comprised the stocks of twelve leading industrial companies. Only two of them—American Tobacco and General Electric—are in the Dow-Jones average today.

Need for Expert Advice

I've said this before, but it bears repeating: Before you buy a stock, find an investment adviser in whom you have confidence, and let him do the selecting.

If it's growth stocks you want, he'll know whether enthusiasm for this or that stock has brought it to a price level that may be out of line. He'll know whether the capitalization of the company is such that the investor gets a fair deal. He'll find out whether the management owns a good piece of the business (it's surprising how many managements don't). And he'll discuss with you whether or not the shares of the company actually do fall into the growth-stock category. END

Six Idea-Producing Offices

Home-office on a hillside · Workshop for a G.P. · Doctor, dentist, optometrist under one roof · Well-equipped clinic for two · Four specialists build on a narrow lot · An urban office for seven

By Roger Menges

● Looking for an office plan that suits you to a T? You won't find it among the six recently built offices featured on the following pages. They're not meant to serve as perfect, or even as near-perfect, examples.

They *are* meant to stimulate your thinking, to give you ideas you can adapt for your own use, and to show you how other physicians have tackled problems that may confront you.

If, for example, your lot has a sharp slope, you may pick up some ideas from the plan on page 116. If your lot is narrow but deep, check page 124. If your lot is sandwiched between buildings that threaten to limit your supply of sunlight, see page 126.

No matter what the size or type of office you plan to build, you can profit from the lessons learned by those who have built before you. Most of the doctors who occupy the buildings shown in these pages seem agreed on the following:

Preparation: Don't start to build until you've spent several years in a rented office. To decide exactly what you need, visit as many other medical buildings as possible; and look for their faults as well as for their strong points. Above all, don't make your decisions too swiftly. It's impossible to give *too* much time to the preliminaries.

Over-all planning: Don't underestimate your space needs. If possible, allow for growth by buying extra land and by planning a structure that can be easily enlarged. You may need much more room some day; so plan for it now.

Waiting room: Put it within easy reach of the main entrance and of the secretary's quarters. But isolate it as far as possible from circulating nurses and patients.

Secretary's office: The ideal spot is close to both the entrance and the waiting room. That way, the aide can control arriving and departing patients and can also direct others to the treatment area. At the same time, her office should be near the doctor's work area, for easy access to records and for supervision of traffic within the suite.

Consultation-treatment area: Rooms in this section should afford complete privacy yet be readily accessible from each other. Doors between adjoining rooms often do the trick. But, remember, they also decrease usable wall and floor space—unless they're the sliding type.

Consultation room: Best location is near both waiting room and secretary's office. But it must be sufficiently soundproof to afford full privacy for your interviews with patients.

Examining and treatment rooms: It's well to have at least two, designed for interchangeable use. Thus, while you examine Patient A in one room, your nurse can prepare Patient B in the other. By allowing you to handle more patients in the same amount of time, the second room will generally prove well worth the added expense.

Separate entrance: This gives you the advantage of being able to leave the suite without passing the waiting room. It may also be used for patients whom you want to detour around the waiting area, as well as for deliveries of supplies. END



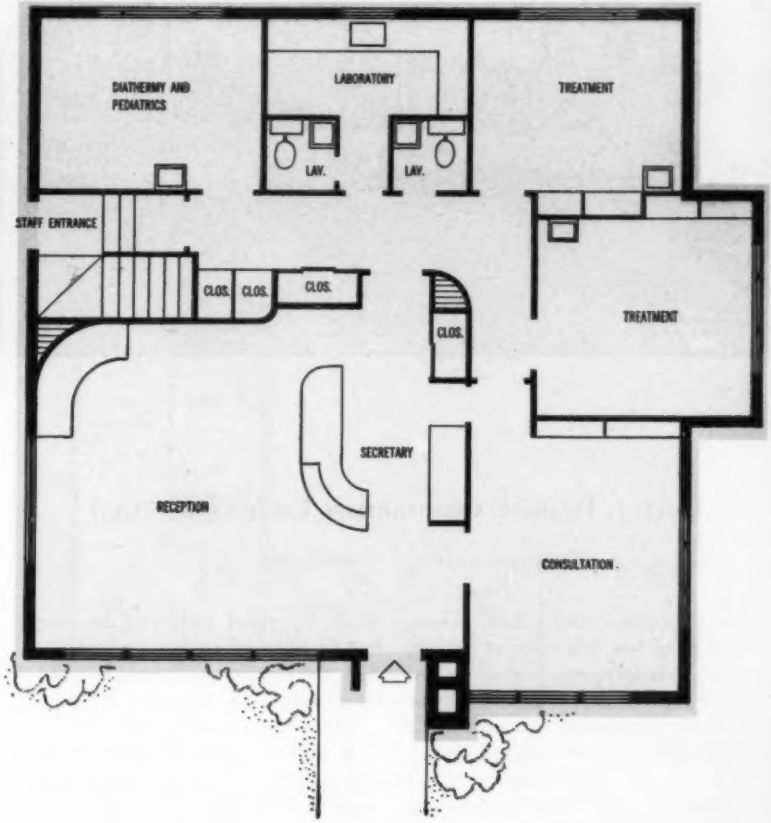
Workshop for a Busy G. P.

This unpretentious-looking brick building, occupied by Dr. J. B. Miner of Charles City, Iowa, is styled for heavy patient traffic. It has three treatment rooms (one for diathermy and pediatrics); two lavatories (one for the staff, the other for patients); and a lab, conveniently located between two treatment rooms. A small double window between patient's toilet and lab simplifies the transfer of specimens.

In the basement, a large den—with fireplace, closet, toilet, and shower—provides a retreat where the doctor can meet with friends and associates.

The building is air-conditioned. Its flat roof is built up around the edges, so that it can hold three inches of pipe-supplied water, for extra insulation against summer heat.

If he had it to do over, the doctor says he'd cut the size of the reception room, convert the extra space into working area.



ARCHITECT: CHARLES ALTFILLISCH, DECORAH, IOWA

[MORE→



Home-Office on a Hillside

Though few doctors would choose to build on the side of a hill, some are forced to. Such was the experience of R. Hough Weisel, a general practitioner who practices in the mountainous Pocono region of Eastern Pennsylvania.

But his steeply sloping site actually proved an advantage for a home-office. It enabled the architect to place the office wing a half flight lower than the living quarters, thereby insuring more domestic privacy. Office and home areas are connected through the lab, which helps muffle noises from either direction. Since the lab is also used for dispensing (there's no drug store in town), its outside entrance is handy for deliveries.

The doctor has allowed no space for a receptionist because such "frills" are frowned on in the small (pop. 1,200) village of Bowmanstown. His wife pinch-hits during rush periods.

The building is made of gray field stone, which comes from near by.

XUM



ARCHITECT: PAUL HEIDLER, EASTON, PA.

[MORE→

XUM



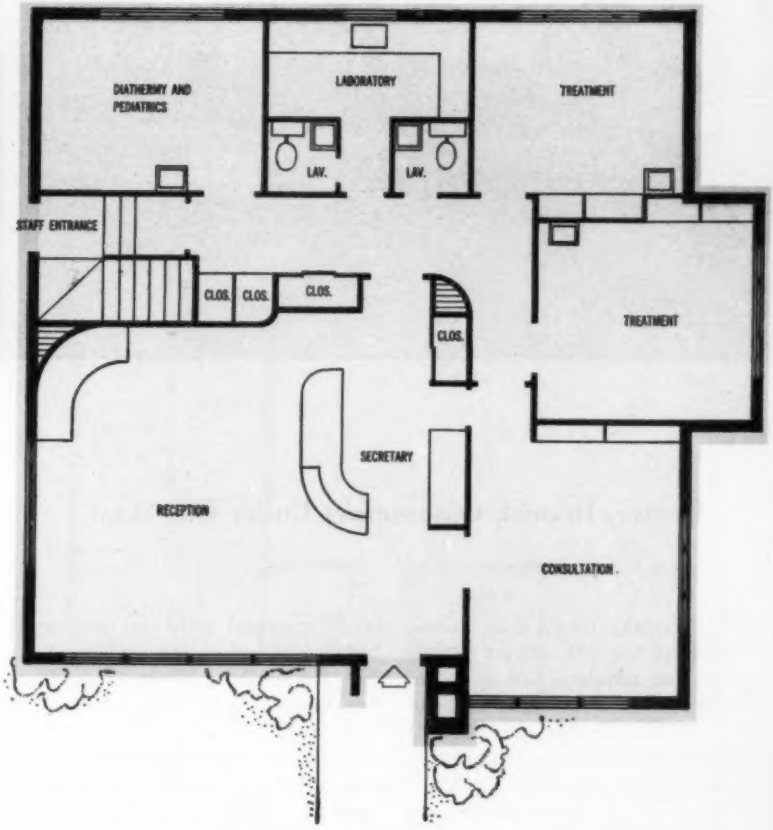
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ARCHITECT: CHARLES ALTFILLISCH, DECORAH, IOWA

[MORE→



Doctor, Dentist, Optometrist Under One Roof

Many doctors would flatly refuse the risk of building without the advice of an architect. Not so Dr. L. E. Kresler of Rensselaer, Ind. He adapted his Bedford-stone, ranch-type office from house plans featured in a woman's magazine.

A dentist and an optometrist have suites in the left and center sections, respectively, while the physician occupies the right wing, which was extended in the rear.

Three treatment rooms, two identically equipped, help the doctor handle more than fifty patients a day. The smallest treatment room is used for giving injections and intravenous fluids, and for recovery.

In the rear, there's parking space and a tiled patio for the use of patients in warm weather. The secretary's office is close to the waiting room and to both front and rear entrances; but it's not so convenient to the consultation room as most physicians might want.


SURGERY
SURGERY
PARKING
LABORATORY
Dentist
RECEPTION
LAV.
HEATER
LAV.
PATIO
Optometrist
EXAMINATION
LABORATORY
CONSULTATION
RECEPTIONIST
TREATMENT &
RECOVERY
TREATMENT
LAV.
CLOS.
CLOS.
RECEPTION
G.P.
CONSULTATION
LABORATORY
TREATMENT

[MORE→



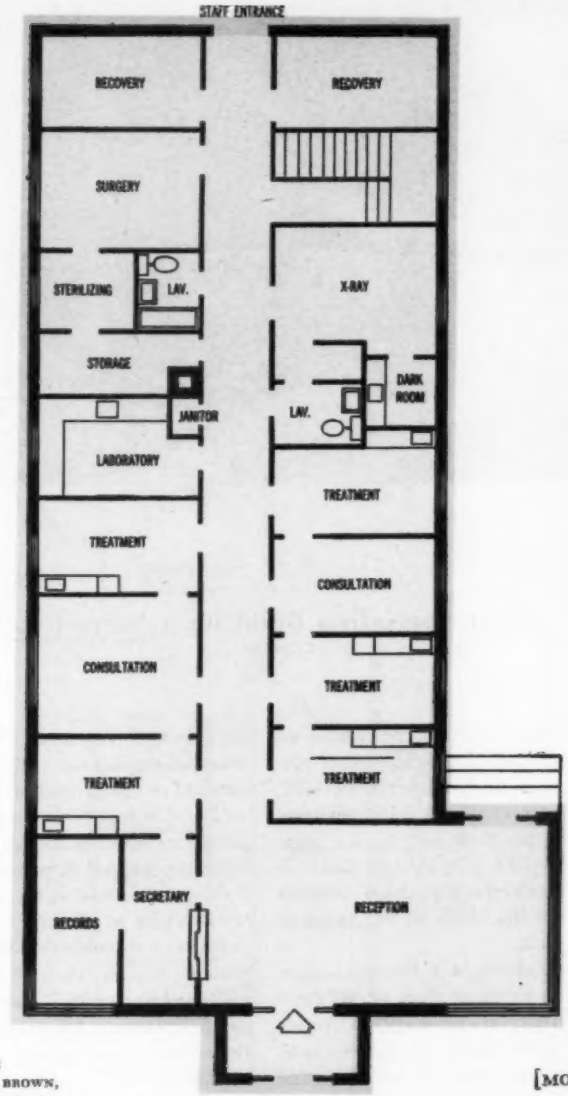
Well-Equipped Clinic for Two

A wide variety of cases can be handled by the father-and-son team who staff this clinic in Ponca City, Okla. Its five treatment rooms, surgery and X-ray facilities, two recovery rooms, and lab—all fully equipped—make possible many of the services usually performed at a hospital, say Drs. R. B. and R. W. Gibson.

Although the building is long and narrow, the most frequently used rooms are clustered in one compact area. Notice, for example, how each consultation room is flanked by two treatment rooms. Down the hall, away from noise and the bustle of patients, are the rooms where isolation is important.

To save time, the doctors have installed dictating machines in each consultation and treatment room.

If they were to build again, they say, they'd allow more space for records and would change the layout to keep patients from peering down the hall into the treatment area.



ARCHITECT:
WILLIAM B. BROWN,
PONCA CITY, OKLA.

[MORE→



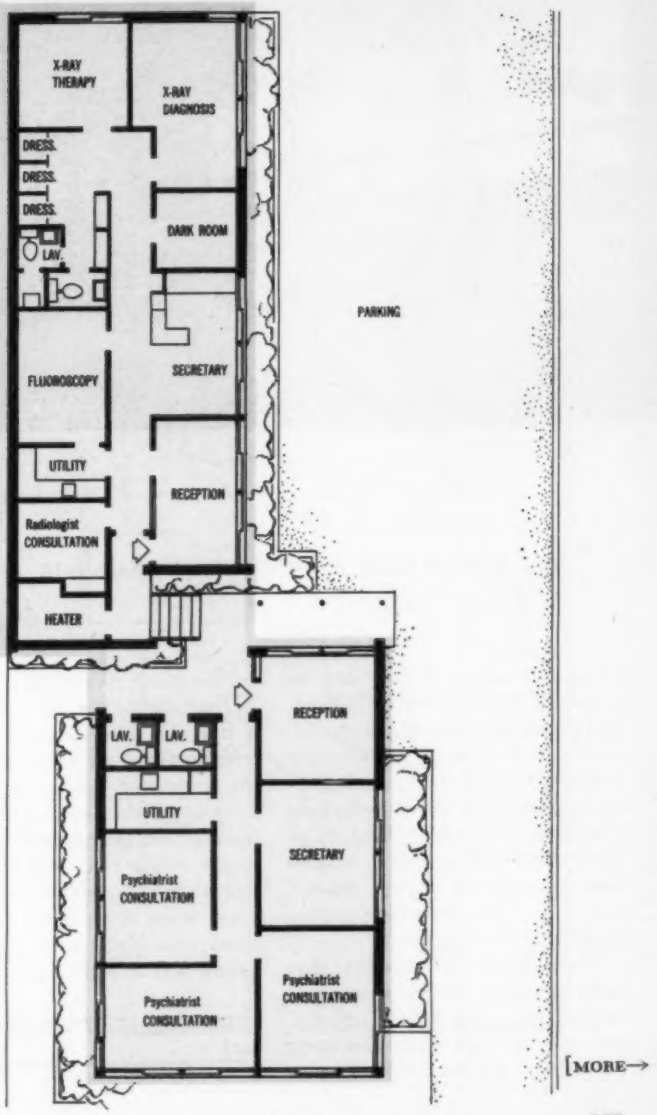
Four Specialists Build on a Narrow Lot

This building illustrates how an architect solved the problem of providing space for four Oakland, Calif., specialists, with off-street parking for their cars, on a narrow but deep lot (50 by 125 feet). It also illustrates the sharp contrast between the needs of two types of specialists.

The radiologist in the rear section takes more space than do all three psychiatrists in front. While his suite is decidedly clinical in look, theirs leans the other way. Outside light was a requirement in their suite, whereas it naturally had to be blocked out in several of his rooms.

The radiologist, of course, wanted lavatories near his rooms. The psychiatrists wanted them set apart, so their users' comings and goings wouldn't be so obvious.

Since a psychiatrist sees fewer patients in a day than do other specialists, his reception room can be small. This one is located away from the street, to give patients a feeling of shelter.



ARCHITECT: ROGER LEE, BERKELEY, CALIF.

[MORE→



Urban Office for Seven Specialists

To provide maximum floor area for the seven San Francisco specialists who occupy this building, the architect had to build to the property line of the lot. This meant that surrounding buildings would block daylight from all sides except the front. So he stepped the roof up and down and inserted windows in the vertical part of each step (see cross-section diagram of building).

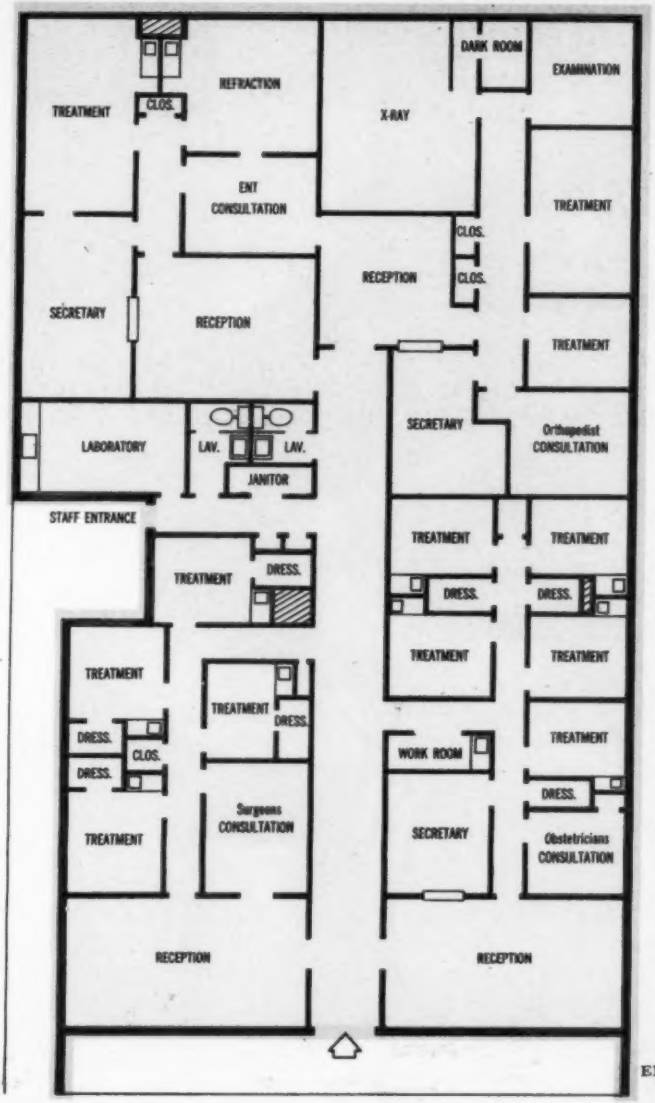
Thus, although three exterior walls contain no windows, each major area has outside light. Front windows are set high above the street for privacy, and the overhang keeps out the direct rays of the sun.

The building was set back slightly from the sidewalk, to distinguish it from adjoining structures. Interior rearrangements can be effected, as necessary, with minimum trouble because the interior walls bear no weight and are covered with sheet rock rather than plaster. The four suites house, respectively, three surgeons, two obstetricians, an orthopedist, and an ENT man.



CROSS SECTION

ARCHITECTS: WURSTER, BERNARDI AND EMMONS, SAN FRANCISCO



ARCHITECTS: WURSTER, BERNARDI, AND EMMONS, SAN FRANCISCO

END



A 'Magic' Plan For Getting Rural Doctors

What makes Virginia's physician placement service outstanding? Chiefly close cooperation between doctors and laymen, says this writer

By Don Cameron

● The series of events that brought young Dr. Jesse M. Tucker Jr. to the tiny (pop. 225) Virginia community of Huddleston made important local news. But the story behind the news has significance wherever doctors are concerned about the shortage of medical care in rural areas.

The Huddleston experience helps explain why the physician placement service set up three years ago by the Virginia Council on Health and Medical Care has been successful. So successful, in fact, that the A.M.A. Council on Rural Health last year called the program "one of the best, if not the best . . . in the nation."

Even so, there were people in Chicago and San Francisco who knew more about Virginia's placement service than anyone in Huddleston knew in the spring of 1951. That was when the Otter Grange, newly organized in the little Bedford County town, met to consider what it



JESSIE M. TUCKER JR. and his secretary, Josephine Howell, plot a route through Huddleston's jumble of back roads. Edgar J. Fisher Jr. [→], director of the Virginia Council on Health and Medical Care, helped bring together Dr. Tucker and his new community.

might do in the way of community improvement.

On the agenda at that first meeting, one fact stood out bleakly: For several years there had been no doctor among the 3,000 people who made their homes in Huddleston and the rolling countryside for ten miles around.

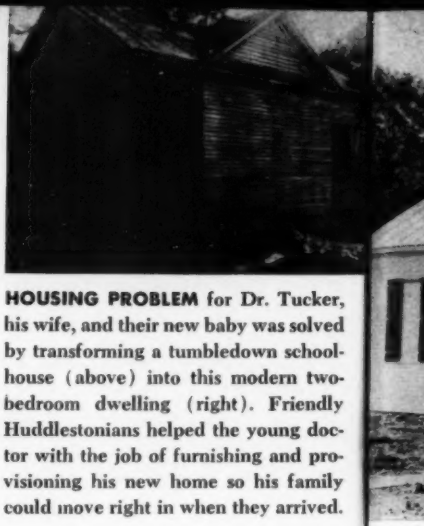
It wasn't because they couldn't afford one. They'd kept the late Dr. John Pollard busy for thirty years. And when Dr. Pollard had considered moving his practice to Lynchburg before he grew too old to wrestle with the muddy side roads in bad weather, he had tried to find a younger man to take his place.

But the young men he had approached had different plans. So Dr. Pollard had finally died, leaving no one to look after his old patients.

No Adequate Care

Ever since then, folks had been traveling fifteen miles to the busy doctors at Bedford, the county seat, or farther still to Lynchburg, which had the nearest hospital and ambulance. If a man's shin got in the way when he was chopping wood, it took half a day in good weather to get the wound stitched and bandaged. And if an expectant mother faced unexpected trouble in the back country in winter, the emergency was likely to be over before a physician could reach her.

So the need was real enough. But with the demand for country doctors far ahead of the supply, how could a town like Huddleston hope to find one?



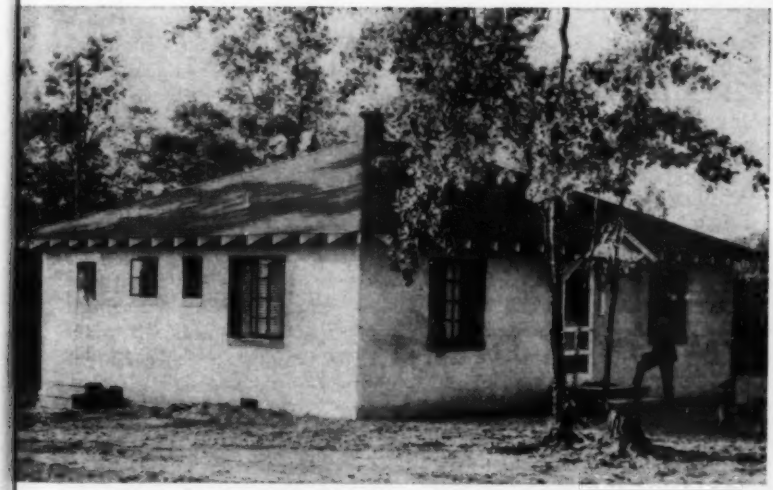
HOUSING PROBLEM for Dr. Tucker, his wife, and their new baby was solved by transforming a tumbledown schoolhouse (above) into this modern two-bedroom dwelling (right). Friendly Huddlestonians helped the young doctor with the job of furnishing and provisioning his new home so his family could move right in when they arrived.

A representative of the Virginia State Grange, down from Richmond for the 1951 meeting, had the answer: The State Grange, one of the supporting groups of the Virginia Council, had already taken part in several successful community campaigns for physicians. If Huddleston was willing to do what it could to make itself attractive to a doctor, the representative was sure that the Council would help.

So, on that very evening, the Otter Grange created a "doctor committee" and instructed it to find out what ought to be done and how to do it. Next day, Joe Goode, the new master of the Grange, wrote a letter to the Richmond headquarters of the Council.

[MORE→





NEW COMMUNITY CLINIC built by people of Huddleston cost $6,000. Dr. Tucker, who paid for the land it occupies, will use the building rent-free for a year. Thereafter, as his practice grows, he'll pay rent or may buy the clinic.

From this point on, the business was carried forward by these orderly, undramatic steps:

First, Paper Work

1. As soon as Edgar J. Fisher Jr., the Council's energetic young director, received Goode's letter, he wrote back that the Council would do all it could to help. And he sent along a questionnaire that, when filled out, would provide a comprehensive picture of the community's economic, social, and physical aspects.

2. At the same time, Fisher wrote to the Bedford County Medical Society for a professional diagnosis of the situation. This procedure, which is always followed by the Council, makes certain of the answers to three vital questions: (1) Is the community's need for a doctor genuine? (2) Can the community support a doctor comfortably? (3) Are the other doctors in the area willing to cooperate with a new man?

3. Within two weeks—favorable answers having been received—a descriptive paragraph about Huddleston was added to the Council's list of communities in search of doctors. The list, kept up to date, is sent to all physicians and senior medical students, in Virginia and elsewhere, who contact the placement service.

4. The Council's list of fifty-odd doctors in search of locations went to Joe Goode in Huddleston. With it went notes on constructive steps taken by other rural communities to attract doctors.

Just a month after that original meeting of the Otter Grange, Fisher made the first of several visits to Huddleston. Meeting with Grange members, and later with a committee representing all community groups, he discussed several down-to-earth facts. Among them:

¶ Young doctors starting out in practice are seldom well off financially.

¶ Good housing and office facilities are important both in getting and in keeping a doctor.

¶ Community investments in such projects often pay unexpected extra dividends.

He took pains to make crystal clear the Council's one inviolable rule: While it would gladly furnish unlimited information, guidance, and advice, *the community itself must do the job.*

"That's just common sense," Fisher explains. "There isn't any magic formula for success; but if there were, our rule would be an essential part of it. You might almost say we lean backward to be sure that the local people do everything *their* way, not *ours.* Why? Because it has been shown over and over again that when a program is imposed on a community from outside, it usually isn't permanent."

Two-Way Inspection

Before the summer was over, Huddleston had corresponded with most of the doctors on the Council's list. A number of them came to look

the ground over. They found certain obvious disadvantages (chief among them a total lack of practice facilities). But they also found the community willing to take corrective action. Thanks to Fisher's briefing, and to advice from Bedford County physicians, Huddleston had a fair idea of what was needed, and was eager to provide it.

Several of the young physicians thought they might like to practice in Huddleston if satisfactory arrangements could be worked out; and Huddleston would have been pleased to have any of them. But nothing had been settled when, one day, young Dr. Tucker arrived on the scene.

Jesse Tucker's approach was different from that of the other candidates. Like some of them, he had agreed to spend at least four years in rural practice, in return for his scholarship at the Medical College of Virginia; but unlike many, he looked forward to spending a *lifetime* in the country.

First of all, Tucker—then an interne at Norfolk General Hospital—had a long talk with Fisher. They discussed various communities that were in the market for doctors. But Tucker liked best what he heard about Huddleston.

Gets Lay of the Land

Then, when he and Mrs. Tucker finally drove to Huddleston for a first-hand appraisal, they did it the hard way. They chose a meandering course through back roads in the last downpour of a two-day rain.

"I wanted to get the feel of the land," Tucker said later. "And I got it. I learned, for one thing, that I'd need a car with mud-tread tires and with a short wheelbase that wouldn't hang up on the crown of a rutted dirt road. On that first trip, there were a couple of times when we thought we'd never make it."

In Huddleston, Tucker talked to a lot of people besides the men and women of the "doctor committee." Probing beneath the surface to get the real flavor of local life, he was impressed by their community spirit. He was even more impressed by the numbers of young people who—instead of suffering from the get-away itch that plagues so many rural districts—were convinced that Huddleston was a good place to live.

"Build me a small clinic and find a good home for me and my family," he told the committee finally, "and I'll come to stay, as soon as my interneship is over."

They Meet His Terms

The committee members, impressed by their six-foot, 30-year-old visitor, agreed to do their best. And they were as good as their word.

Drawing again upon the Virginia Council's advice, the committee lined up all the citizens of the community. Three men were elected to constitute a trust company, which

was empowered to make all necessary arrangements. Legal and financial matters were placed in the hands of three trustees in near-by towns—a lawyer and two bankers.

Through an exchange of letters, Dr. Tucker and the trustees drew up a legal agreement. Under it, Tucker demonstrated his faith in Huddleston by buying a twenty-five-acre tract at the edge of town and deeding one acre to the trust company. On this acre, the trust company contracted to build a $6,000 cinder-block office building according to Tucker's own plans.

The building—comprising reception room, office, examining room, X-ray room, and laboratory—was to be placed at the doctor's disposal without charge for the first year. Thereafter rent would start at $500 a year; and Tucker would be given a ten-year option to buy the structure at cost.

Raising the money was no problem at all for the community. Individual subscriptions ranging from $33 to $40 more than made up the needed sum, and work was started without delay.

School Into Home

The question of a suitable house for the doctor and his family caused some worry at the start. No modern place was available, and the trust company hesitated to extend its building operations.

Curiously enough, the most forlorn-looking building in the community solved the problem. Quite near the site of the clinic stood an abandoned one-room schoolhouse, weatherbeaten and paintless. Fred Fuqua, a Lynchburg contractor, had bought it for sentimental reasons; his father had built it in 1900, and he had gone to school there as a boy. Now he offered to build a modern two-bedroom dwelling on the sturdy old frame, if the doctor would agree to rent it for $70 a month—and *that* was taken care of.

Several things happened nearly coincidentally last summer: The clinic, the house, and Dr. Tucker's interneship were all completed; and the Tuckers' first baby, Jesse M. III, was born. On September 8, when the baby was two weeks old, the new doctor arrived in Huddleston to get things ready for his wife and son.

No Breathing Spell

But the young physician had barely got to town when Huddleston began to prove its need for a doctor. His first patient, the day after he arrived, was the wife of Bedford County's former chief fire marshal. Immediately thereafter, a local businessman suffered a badly lacerated foot in an accident. Then came an obstetrical emergency, followed by an emergency at the Huddleston School, where one of the children was having convulsions after a stroll through a poison ivy patch.

It went on like that all through the first month. Often the doctor got to bed at 2 A.M., [MORE ON 199]

Korea: a Challenge To the American Physician

By developing a strong corps of doctors in this war-torn country, says Dr. Howard A. Rusk, America can help build a bulwark of freedom

By Mauri Edwards

● The end of a war is often only the beginning of a problem. Korea's problem, it was clear from the start, would be reconstruction—rebuilding crippled cities, industry, and people.

Yet there is wide agreement throughout the West that this is actually more than a Korean problem. For if the Koreans have nothing to look forward to, then the West will lose a golden opportunity to establish a fortress of freedom in the Far East.



Rusk on his Korean tour

Fortunately, it's already clear that Korea won't be let down. Official agencies (such as the United Nations Korean Reconstruction Agency) and voluntary organizations (like the American-Korean Foundation) are actively planning to help Korea rebuild.

But there's work to be done by individuals, too. And because a major phase of Korea's problem is the need



OVER THE TEACUPS in Taegu, Dr. Rusk outlines his plans. His listeners are youthful R.O.K. Chief of Staff, General Paik Sun Yup; American Major General C. E. Ryan; and Brigadier General Yoon Chi Waang, R.O.K. Surgeon General.

for a sound health program, no individuals are playing, or can play, a more vital role than American doctors.

This estimate of the Korean situation was recently placed before MEDICAL ECONOMICS by Dr. Howard A. Rusk, director of the Institute of Physical Medicine and Rehabilitation of the New York University-Bellevue Medical Center, and associate editor of the New York Times.

Rusk's first-hand knowledge of Korea stems from a recent visit he made to the Far East under the auspices of the American-Korean Foundation, a voluntary organization concerned with Korea's reconstruction. Though unofficial, it has official blessing; its chairman is Milton S. Eisenhower, brother of the President.

Dr. Rusk and a group of colleagues spent eight concentrated days in Korea, observing and making recommendations. Here is Rusk's

picture of the situation, as he drew it for MEDICAL ECONOMICS.

An enormous job needs doing if the Koreans are to receive adequate medical care. To get an idea of the size of the problem, just suppose that you're a Korean doctor. You're the only medical man available in an area of 23,000 people.

In three years of war, opposing armies have made a shambles of your city. By now, most of the people live in hovels, without sanitation, and without enough food. Most of them get by on 1,500 to 1,800 calories a day. More than 1,000 Koreans in *your limited area alone* have clinically significant tuberculosis. Orphans and amputees abound.

But even that's not the full story. Since four-fifths of Korea's general hospitals have been wiped out, there may not be a hospital available for your patients. Because there's just one nurse to 55,000 people, you may not have any reliable help. There's little medicine, no equipment. And, to top it off, you, as a Korean physician, have probably been poorly trained.

Saved by the Americans

That's what faces Korea's average civilian doctor. Only the presence of American physicians has prevented a catastrophe. But one day our medical men will go home, leaving Korea's health problems to the Koreans. To insure that the latter will be able to carry on, American medical men now in Korea are already making these important contributions:

1. Through American and United Nations aid, Korea's six medical schools are being re-established. Half the teachers are American doctors. In their spare time, they teach conversational English as well as medicine.

2. Young Korean medical officers are being given residency training, under American medical officers, in an American field hospital at Taejon. The plan is to train at least twenty Korean M.D.s a year. Actually, the Republic of Korea has promised to provide fifty young doctors for such training this year.

Training Plan

Korean officials approve of the residency plan because they're aware that on-the-job training of Korean doctors can be conducted best in Korea, where the trainees will learn their *own* country's medical problems. If these young doctors were to be sent to America for training, they might be spoiled for Korea. They'd learn American methods, American conditions.

A second important point about training Korean doctors in Korea: It costs a lot less. In fact, most of the aid America can give to the newly developing corps of Korean doctors is inexpensive.

Dollars Go Far

For example, a Korean can be sent to medical school for a year for

$500. And that includes tuition, maintenance, books, and personal expenses.

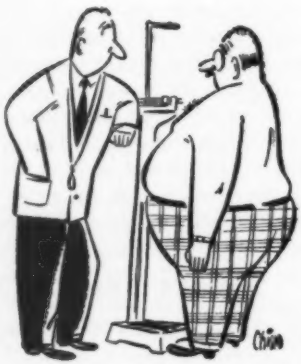
For even less—$350—a charity hospital bed can be maintained for a full year. That includes food, medical care, nursing services, and medications.

On a somewhat larger scale, it's possible to fit out a twenty-bed hospital ward with all the necessary medical equipment, beds, blankets, linen, and other supplies for as little as $1,000.

Amputees and Orphans

In addition to making long-range plans for improving Korea's health standards by increasing and bettering its doctor supply, Dr. Rusk and his colleagues also drew up programs to meet the nation's immediate needs.

Among the most urgent of these are rehabilitation of the disabled and care of the orphan children.



There are now 8,000 military amputees in Korea. To give them a new start, the Rusk mission developed a plan to establish a rehabilitation center near the port of Pusan. The amputees will learn there to use artificial legs and arms that are being supplied by the Korean-American Foundation. Vocational guidance will be given, too. And—to get the project itself on its feet—U.N. workers will train Koreans in rehabilitation techniques.

There are 100,000 war orphans in Korea—almost all of them badly in need of medical check-ups and nutritional build-ups. Rusk's plan for them is to establish one receiving home in each of Korea's provinces. There, the orphans will receive the immediate care they need. Then they'll be sent along to orphanages or foster families.

A Sound Investment

Orphan care, like so many other things, isn't expensive in Korea. An orphan can be maintained for about twenty cents a day. And, as Rusk told MEDICAL ECONOMICS, "a look at the bright, uncomplaining face of such a youngster is ample return on one's investment.

"Essentially," he added, "that's true of everything that America and Americans do in Korea. It's all in our own interest. If we do something about Korea, I think that at long last we'll have an opportunity to win the peace." END

Labor Demands 'Complete' Health Security

'We're not interested in excuses,' says this labor leader. 'Either voluntary health insurance will do the job, or we'll get a compulsory system'

By David J. McDonald

● Any hope for the continued development of Blue Cross and Blue Shield must lie in the recognition that these organizations do not represent exclusively—or even primarily—the interests of hospitals and doctors. In order to succeed, the plans must become community organizations, with wide public representation on their governing boards. They must reflect an intelligent balance of the interests of hospitals, physicians, and members, with no overemphasis on the self-interest of any one of these groups.

Fortunately, there is no basic conflict of interests here. But if the plans fail to achieve a broad, comprehensive system of prepaid hospital and medical care, there *will* be a conflict. At which time you can expect the people of the United States to *demand* a system of Federal compulsory insurance.

It may seem that the present Administration in Washington is so firmly opposed to Federal health insurance that there is no longer a need to broaden and improve existing Blue Cross and Blue Shield plans. Yet this could

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DAVID J. MCDONALD *is president of the United Steelworkers of America.* *This article is a condensation of parts of a speech made by him before the 1953 Conference of Blue Cross and Blue Shield Plans.*

scarcely be further from the truth.

Nothing has yet happened to reduce the burden of health care. Medical and hospital costs have been rising steadily in recent years, and they're still going up.

Is there no way in which to insure ourselves privately against this great financial load? Is it not possible to broaden the range of medical benefits available from private prepayment plans? If the answer to these questions is "No," then I believe the American people will insist that the Government come to their rescue.

What Labor Wants

Take the steelworkers, for instance. Their desire for an adequate health-care plan for themselves and their families has been clear throughout the entire history of their collective bargaining. In the words of their late, great president, Philip Murray:

"The steelworker wants, and is entitled to, protection and security, paid for by the company. Whether his illness or disability occurs as a result of his job, or for any other reason, the steelworker wants medical, hospital, and surgical care provided without having to exhaust his savings, borrow money, or go into debt."

Early in 1954, the United Steelworkers of America will again enter into negotiations with the steel industry to improve and expand our social insurance programs. We can summarize the essential elements of our hospital and medical care proposal under three broad headings:

1. Early diagnostic and preventive medical care;
2. Payment of medical, dental, drug, and appliance bills;
3. Payment of all hospital bills.

This three-way proposal is not unreasonable. And we feel that it *must* be met. Every day, steelworkers are paying a large part of the bills for these services out of their own pockets. They are justified in demanding a comprehensive prepayment program.

I do not know whether Blue Cross and Blue Shield will prove themselves sufficiently flexible to participate in the achievement of such a program. Nevertheless, that is the challenge these plans must face.

Preventive Care

The United Steelworkers of America have demanded—and will continue to demand—insurance that includes preventive as well as diagnostic care. They know the value of such care; and they will not be deflected by the old argument that preventive medicine is too costly. They are well aware that early detection and treatment of such diseases as cancer, heart trouble, and TB will, in the long run, *save* money.

Many of our members in California already receive preventive care from the Permanente Health Plan. Similar benefits are available in New York City through the Health Insurance Plan (HIP). Shall we be forced

to say that preventive care cannot be provided by any of the doctor-sponsored plans?

All Costs Paid

The steelworkers of the country insist, too, that so-called prepayment plans actually *succeed in prepaying*. They deplore the totally unwarranted assumption of some physicians that Blue Shield is not really a medical prepayment plan, but is just a plateau on which a physician is entitled to pyramid his charges.

We who work in the steel industry believe that a prepayment plan worthy of the name provides for the advance collection of premiums to establish a fund from which participants' bills shall be paid *in full*, for the range of services covered by the plan. We want—and I believe we are entitled to—just that, with no excuses.

We see no reason why any services provided in general hospitals, for which patients are billed, should be excluded from our health insurance policies. Certain present exclusions, such as treatment of insanity, are totally unjustifiable.

A steelworker I know of was admitted to a Pittsburgh hospital for treatment of a mental disorder. The services rendered, though costly, were no more expensive than those required by a score of other diseases. Yet this man had to pay his own bills. In my opinion, when a mental or nervous disorder is treated in a general hospital, it should, from an insurance viewpoint, be no different from any other ailment treated in the same institution.

Too often, the effort to cut costs by cutting services has a reverse effect. This is true of plans that restrict out-patient care to emergency service only. Burdensome limitations like these are what encourage the physician to order a patient to the hospital for an overnight stay when only minor surgery and no hospitalization is necessary. Both patients and prepayment plans would



STEELWORKER CHIEF David J. McDonald says the nation may yet demand a Federal health scheme. He's shown leaving a White House parley during the Truman regime, before he became leader of the C.I.O.'s biggest union.

benefit if out-patient care included minor surgery and some of the other now-barred procedures.

Although we have achieved a large measure of uniformity of hospitalization benefits for steelworkers, we have yet to achieve uniformity of surgical benefits. The value of the surgical benefits given members of our union in California, for example, is probably half the value of similar benefits in New York.

Doctors' Fees

I am quite in favor of fair, even generous, fees for physicians and surgeons. But it is impossible to explain satisfactorily why identical surgical procedures should cost our members different amounts in different parts of the country—and sometimes even in the same community.

A recent article in MEDICAL ECONOMICS indicated that doctors collect about 85 per cent of their bills. To me, this means that the average physician is considerably better off when he receives 100 per cent of his fees through Blue Shield. Yet when a doctor who is already collecting 100 per cent insists on making additional charges beyond those provided by the Blue Shield schedule, we believe we are being treated unfairly.

Service, Not Indemnity

There were many reasons in 1949 why the United Steelworkers of America chose Blue Cross and Blue Shield. The simplicity of operation and direct doctor-patient contact these plans offered were important features.

But most important was the fact that Blue Cross benefits were expressed in terms of hospital service rather than cash indemnity. For we are convinced that health care cannot be translated into fixed-dollar values.

When our financial condition permitted the addition of Blue Shield coverage, we were again influenced by the service aspects of the program. Blue Cross and Blue Shield together, we felt, offered the best available protection against illness costs for workers in the steel industry.

The great and growing demand of steelworkers, and all other workers, for comprehensive health insurance gives the medical profession a chance to demonstrate the kind of leadership the world today seeks from the United States. Yours is the opportunity to develop within the framework of private practice and free choice of doctor, a method by which the burdensome costs of medical care may be met through privately organized prepayment plans.

If your organizations rise to the challenge, we are willing to go forward with you. *But whether they do or not, we are determined to fight on until the goal of complete security, medical and otherwise, is achieved for the workers of American industry.* END

How to Tame Young Cut-ups —Without a Shillelagh



It's not easy— but there are ways of getting along with the small fry. For instance . . .

By Wallace Croatman

● Last February, MEDICAL ECONOMICS published an article called "The Hellion." It discussed some basic techniques for handling problem patients of the short-pants-and-pigtails age.

Since then, there has been a lively response from readers. Many of the letters received have described still other techniques—several of which seem worth passing along here.

First, though, a couple of qualifying remarks:

1. Almost no one appears to have any *revolutionary* ideas for handling recalcitrant children. And that's probably all to the good: Since fashions in child psychology change about as fast as a kid grows out of a pair of shoes, the best suggestions are likely to be those that have proved workable over the longest stretch of time.

2. Nor does any reader lay claim to an approach that works on *every* youngster, regardless of age, sex, personality, and the like. Apparently, doctors and their aides realize the importance of treating even young patients as individuals.

Most of the suggestions for getting along with young Merton or Margery fall into one of three types:

¶ You encourage the child to act as the "doctor's helper";

¶ You and he play games with your instruments; or

¶ You attack the problem through the parents.

Get Them to Help

One advocate of the first approach is Marilyn Lesak, an R.N. employed by a Cicero, Ill., physician. It's been her experience that "Children's little minds must be impressed by the fact that Doctor is extremely busy and that they'll just have to help us along."

Accordingly, she has evolved a number of schemes for putting the little rascals to work. Suppose, for example, that there are sutures to be removed. In that case, she hands the child an alcohol-soaked sponge and tells him to hold it over the stitches—"so they'll be all softened up for the doctor."

Often, she admits, a touch of



"I've just become a brother!"

bribery helps. Thus, while she's popping a thermometer into the youngster's mouth, she's also thrusting a lollypop into his hand—with the promise that he can start munching as soon as the thermometer registers. "The next three minutes pass in dead silence," she says. "And nobody's swallowed a thermometer yet."

Or maybe there's a throat examination in the offing. This can pose a real challenge—especially if Junior is old enough to guess what's coming. Nurse Lesak finds that she can usually ease the situation by handing the child two tongue depressors: one to give the doctor, the other to take home.

The Playful Approach

The play-games-with-the-instruments approach has one obvious drawback: There's always the possibility that some over-precocious scalawag will refuse to give back the instrument once he's got his hands on it.

For that reason, few medical men advise trying the technique on *every* hard-to-handle youngster. Even so, they maintain, the loss of an occasional percussion hammer is a small price to pay for a workable means of keeping kids in line.

This approach, moreover, allows for the obvious fact that a child's contrariness often springs more from apprehension than from perversity. And even the most sinister-looking instrument can sometimes be used as a prop in winning a youngster's confidence.

It Takes Patience

Here's how Dr. Leo Schnur of Grand Canyon, Ariz., puts the difficult child on friendly terms with an otoscope:

"First I hand the instrument to the parent," he says. "This shows young Rudolph that it's harmless after all. The parent then hands the instrument to Rudolph. Generally, he's fascinated by it; so I offer to show him how it works.

"I tell him to press the head of the 'scope. While he's doing that, I turn the rheostat. He's amazed to see the gadget light up—apparently at his own doing. Then I say, 'If you blow real hard, maybe the light will go out.' And sure enough, following the third puff or so, it *does* go out. After that, I generally place the otoscope in my own ear and let him look into it. The rest is easy."

Use Parents, Too

Instruments are fine as far as they go; but the routine is even more effective, some physicians feel, if parents are brought into the act.

For example, consider how Dr. Edward E. Brown of Ashland, Ore., conditions a squalling infant to a stethoscope. While the child squirms on the mother's lap, Dr. Brown claps the stethoscope on the mother's arm and starts listening with apparent interest.

Sometimes this is enough to quiet

the youngster. If not, the doctor says, "You'll have to make less noise, Mother, so I can hear my telephone." By now the little fellow generally shows a keen interest in the maneuver. So the doctor switches the stethoscope to the child's arm, then to his heart and lungs. He reverts briefly to the mother's arm only if the youngster starts to act up again.

Get Rid of Mother?

Of course, some practitioners frown on this device of using the parent as a go-between. They maintain that the best place for Mother during the child's examination is outside the examining room.

Dr. George S. Klump of Williamsport, Pa., puts it this way: "There are no problem children—only problem parents. I simply exclude the parent from the child's view and proceed to treat the patient as an intelligent person. It works."

When he's on a house call and at a sick child's bedside, Dr. Klump adds, he tries to get the mother to busy herself in another room. "When I eventually come out, I often find her with knuckles white from gripping the arms of her chair. But, chances are, she's amazed—and relieved—at the tantrum that never materialized. And who knows? Next time she may even get some chores done!"

Gives Child a Choice

Unfortunately, some kids, who are bad enough when their mother's in the room, become even worse when she's asked to leave. But, says Dr. William B. Schafer of Montrose, Calif., there's a way out of even this dilemma:

"You simply give the youngster a two-way choice: Keep on yelling—in which case Mother will have to stay out of the room. Or quiet down and get her back. He'll almost always prefer to calm down."

Avoid Brute Force

Although not all the foregoing ideas may be equally effective, they do have one point in common: They aim at winning the child over to the doctor's side, rather than at cowing him into submission.

One medical man, it's true, claims to get good results in extreme cases by trussing up Junior from toe to shoulder in a specially reinforced sheet, which is kept on hand for just such occasions. A single session in this glorified strait-jacket, he says, is enough to tame the most unruly youngster.

Maybe it is. Somehow, though, when we think about this method, we envision two pictures of possible results:

Picture No. 1 shows the kid, a six-footer by now, pinning said doctor in his own sheet and dunking him several dozen times in the nearest body of water. Picture No. 2 (even more distressing) shows a gaunt, thoroughly cowed little shaver getting the shakes every time he sees a man with a small black bag. END

Partnership Practice: In Case of Dissolution

When one partner withdraws or dies, what happens to the partnership's assets and accounts? Here are some typical agreements on this score

By Henry C. Black and Allison E. Skaggs

● Partnerships, like people, don't last forever. Dissolution usually comes when one doctor dies or retires. And sometimes it comes a lot sooner than that.

What can cause premature break-ups? In our experience, three things:

1. Personality conflicts. Two psychiatrists, for instance, were aggressively opposite types. The younger partner enjoyed an active social life—so active that the senior thought he must be neglecting his work. Actually, he wasn't. But when the partners' *wives* took up the argument, the partnership couldn't survive—and didn't.

2. Professional conflicts. Two anesthesiologists found they didn't think alike on certain standards of care. The senior took to criticizing the junior openly; the latter returned the criticism behind the senior's back. Both partners soon realized they'd better cut loose from each other.

3. Financial conflicts. An internist raised his new associate to full income equality within eighteen months. Then he discovered that the younger man wasn't worth

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**This article is the fifth and last of a series. Earlier installments (in November, December, January, and May) dealt with the pros and cons of partnership practice, how to get started in it, division of income, and the written agreement. The authors have gained their experience in such matters through twenty years of operating Professional Management of Battle Creek, Mich.*

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*Jeans, P. C., and Marriott, W. McKim: Infant Nutrition, ed. 4, St. Louis, C. V. Mosby Co., 1947.

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it; he wasn't physically able to maintain the senior's pace. Tension arose between them, and the partnership eventually broke up.

How to Stop

Typical cases, these? No, they're not. The great majority of medical partners manage to smooth out such differences. But there are exceptions, as noted above; and they illustrate a useful lesson:

The most vital question about any partnership may well be, "How does it stop?"

The answer isn't easy to come by. It has legal and tax aspects, as well as professional ones. But that makes it all the more important to settle in advance.

Obviously, you can't compose the dissolution clauses of a partnership agreement without expert help. Your decisions may come more easily, though, if you know something about what other doctors have done.

The Voluntary Break

"Suppose one partner in the future wants to withdraw voluntarily," you ask. "What decisions should we make in advance to provide for this?"

Well, you'll probably want to decide such points as the amount of notice required; the distribution of assets and accounts; and the rights to the office location. Here's how some typical agreements read on these points:

How much notice? Some doctors settle for a broad statement like the following: "This agreement shall continue in force until terminated by mutual consent . . . "

Usually, however, the clause is made more specific (" . . . until sixty days after written notice by one of the partners that he intends to withdraw . . . "). The time interval may range from thirty to ninety days.

Ownership Problem

Who gets the assets? The partners sometimes agree to divide up their equipment piece by piece. Thus: "In case either partner shall voluntarily withdraw, the partnership equipment shall be divided equally between them . . . "

More often, it's agreed that one partner will buy up *all* the physical assets. It may be the senior partner who's given purchase rights. Or it may be the non-withdrawing partner, for instance: " . . . The remaining partner shall purchase the other partner's interest in the physical assets of the partnership at their book value (cost less depreciation) . . . "

The Waiver Clause

What about accounts receivable? While the partnership lasts, net income is divided according to the partners' percentage schedule. If the combination breaks up, the cash still coming in *may* be divided the same way. But the senior partner often wants a waiver clause—an agreement by the junior to waive his income rights if he withdraws from

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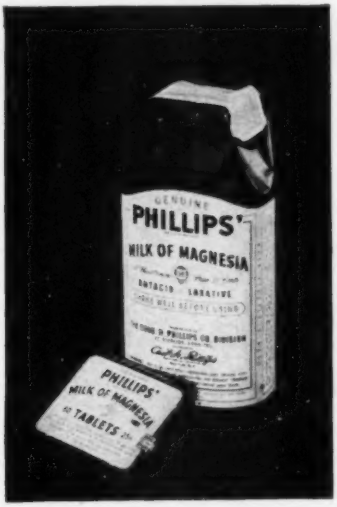
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the partnership during the first few years.

Here are two possible wordings for such a clause:

¶ "If the junior partner withdraws at any time during the first three years, settlement with him shall be limited to the book value of his interest in the partnership assets, exclusive of accounts receivable . . . "

¶ "In the event that the second party withdraws from the partnership prior to January 1, 1958, he shall receive only one-half of that portion of the accounts receivable which he would otherwise be entitled to receive . . . "

The waiver clause usually binds the junior physician for two to five years. And sometimes it's extended beyond that in modified form. Then it becomes an agreement whereby the withdrawing partner loses his income rights if he enters solo practice in the same town.

Who takes over the office? Quite often, it's the non-withdrawing partner. But if the senior founded the practice, he may be entitled to keep it—even when *he's* the one who withdraws. That's the reasoning behind these two sample clauses:

¶ "Upon the termination of this partnership at any time, the partner entitled to more than 50 per cent of the net income shall have exclusive right to office space, telephone numbers, and office records . . . "

¶ " . . . In the event of such dissolution, the first party shall have the right to retain any lease and possession of the offices occupied by the partnership, and the second party shall receive no compensation therefor . . . "

Dissolution at Death

So much for voluntary dissolutions. Now, what about involuntary ones? "Suppose one of the partners dies?" you ask.

In this event, the questions posed earlier almost answer themselves. The surviving partner is generally bound to (1) buy up the partnership's assets, (2) collect its outstanding bills, and then (3) pay the deceased's estate his full share. Here's the simplest expression we've seen of this basic procedure:

" . . . The deceased partner's share of the physical assets shall be purchased by the survivor; and payment shall be made to the personal representative of the deceased therefor. The survivor shall also liquidate the accounts receivable, paying the deceased's representative the percentage due to such deceased partner as of the date of his death . . . "

Naturally, some new questions do arise in this connection. They concern the purchase agreement, the collection methods, and the pay-off plan. We'll provide illustrative answers, but with this warning attached: You need legal advice on the finer points!

What purchase price? Book value —cost less depreciation—is the price usually set on each partner's share of the physical assets. Occasionally, though, the doctors agree in advance



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may be prescribed for any form of anemia—hypochromic, microcytic, macrocytic, normocytic, or pernicious—for it supplies in each easy-to-take tablet five ingredients needed for adequate treatment of any and all of these blood diseases. Binaemon contains Bifacton® (Vitamin B_{12} with Intrinsic Factor Concentrate), 1/9 U.S.P. unit; folic acid, 0.8 mg; vitamin C, 50 mg; ferrous sulfate, 133 mg; and liver concentrate, 100 mg. Because Binaemon supplies intrinsic factor, it provides a safe hematinic, for it assures B_{12} absorption and prevents folic acid from masking the symptoms of incipient pernicious anemia. Prescribe Binaemon for all your anemic patients.

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on a cash figure. It may be a flat $5,000. Or it may be "$6,500 less 10 per cent depreciation for each year the partnership lasts."

However it's done, try to indicate the purchase price in your written agreement. This assures a speedy settlement for the dead doctor's widow; it may also mean certain tax advantages for the surviving partner.

The Trust Idea

How to provide purchase funds? A surviving partner needs ready cash—the wherewithal to buy up the assets. So the doctors frequently agree to an insurance trust arrangement, like this:

"Each partner shall make application for insurance on the other partner's life in the amount of $5,000, said policies to be issued in the name of the Middletown Trust Company, a banking corporation, as beneficiary . . .

"Each partner shall also execute and deposit with said trust company an assignment of all his interest in the physical assets of said partnership . . .

"Upon the death of either partner, the trust company shall collect the insurance proceeds and pay them to the duly qualified representative of the deceased . . . The trust company shall also deliver to the surviving partner the assignment of the deceased's interest in the physical assets of said partnership . . . "

Thus the widow gets the purchase price; the surviving partner gets the assets; and the transfer is accomplished without costly delays or lump-sum outlays.

How will collections be handled? The accounts carried on the partnership's books may add up to many thousands of dollars. And, of course, the deceased's estate is entitled to his percentage share. But the surviving partner is generally given full control of collection methods. Note this typical clause:

"It is recognized that the collection of accounts receivable for professional services is not upon the same basis as the accounts receivable of a trade or business . . . The partnership's outstanding bills shall be collected in the discretion of the surviving partner as to terms and amounts, and no third person shall have any voice whatever in such collection . . . "

When will the deceased's share be paid? The collectibility of such accounts is sometimes estimated in advance, and a quick settlement arranged on that basis. Suppose two partners have agreed to share income equally. Suppose they estimate that collections after death might run about 85 per cent. They might then agree that the deceased's share would be paid promptly—85 per cent of 50 per cent of the partnership's outstanding accounts.

More often, the deceased's share is paid when, as, and if collected. Here's a sample of this agreement:

"The surviving partner shall pay to the deceased's [MORE ON 193]

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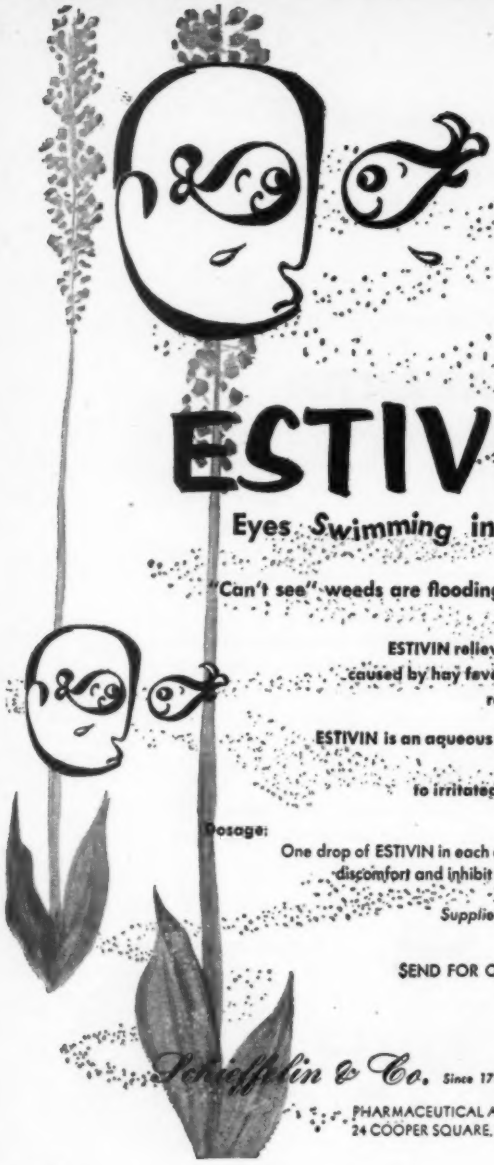
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- low blood level–bactericidal urinary concentration
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- oral administration
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Loan Plans Spur Patient Pay

How they work · Cost to the doctor · Why M.D.s approve · Not for indigents · The usual set-up · If patient defaults · Choice of arrangements · How to start one · Some sample plans

By Don Cameron

● The patient, a construction worker, agreed that something ought to be done about his hernia. But he added that the $150 surgical fee, while perfectly fair, was out of the question, even though Blue Cross would take care of most of the hospital bill. A new baby, it seems, had just unbalanced the family budget. Later on, maybe in two or three months . . .

"You may not be *working* later on," said the doctor, "if we don't operate *now*."

Well, that was a risk a man just had to take if the money wasn't there and he didn't feel he could borrow it handily . . .

"Oh, it's not that bad," said the doctor cheerfully. "I'll see that you get the operation, no matter what. Have you heard about those medical loans the bank extends? They've helped out a good many patients here in town. Perhaps I could get *you* one. Then you could pay your bill more easily, in installments."

That would be fine, said the patient. But could a man without even a savings account get such a loan?

"He often can," said the surgeon, "if he has a steady

**While information for this article was drawn from many sources, it was prepared largely with the aid and advice of Louis J. Asterita, deputy manager of the American Bankers Association and secretary of the A.B.A.'s Installment Credit Commission.*

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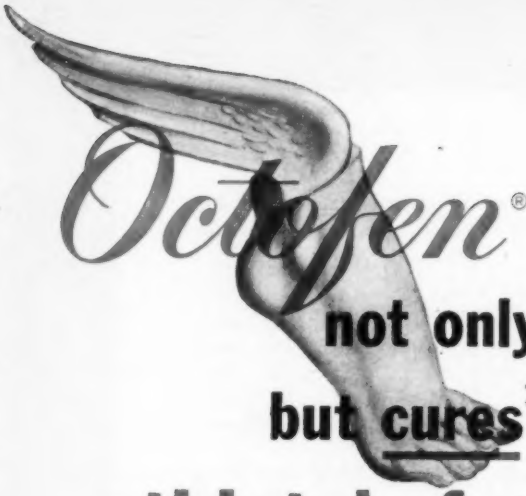
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* **Oster, K. A., and Golden, M. J.: Exp. Med. & Surg., 7:37, 1949**
...mild cases cured in one to two weeks treatment...moderate infections cured in two to four weeks... severe, long standing chronic cases cured within three months...

job and if his doctor recommends the loan. To save *my* patients a trip to the bank in such cases, my secretary keeps a few bank loan application blanks on hand here. If you'd like to fill out one of them before you leave, she'll be glad to do the rest for you."

How They Work

This was good news to the patient. He filled in a short form with information about himself and his job. Then he signed a note for $150, plus 6 per cent interest, plus 1 per cent for life insurance, for a total of $160.50 to be repaid in twelve equal installments. He departed, visibly relieved—and amazed at the simplicity of the procedure.

Almost immediately, the doctor's secretary phoned the essential facts to the bank. The bank's investigator satisfied himself about the applicant's job, circumstances, and character; then he phoned back that the loan had been approved.

Two days later, the operation was performed. Next day, the doctor endorsed the patient's note and sent it to the bank, which promptly paid $148.50 into the doctor's account.

Cost to the Doctor

The $1.50 the physician *didn't* get (1 per cent of his fee) went into a reserve pool account maintained jointly by all the doctors and dentists participating in the health-financing plan. Against that account, the bank could charge losses on uncollectable loans. But whether or not the bank collected in full from the patient, the doctor had 99 per cent of his fee—and no further obligation in the matter.

Not that there was much doubt that the bank would collect. Its quick investigation had verified that the applicant was a good risk.

Since starting its medical time-payment plan in 1948, the bank had found such borrowers even more reliable than it had anticipated. Originally, 3 per cent of the face value of each note had been withheld for the reserve pool. But when the reserve began piling up, the withholding rate had been cut to 1 per cent.

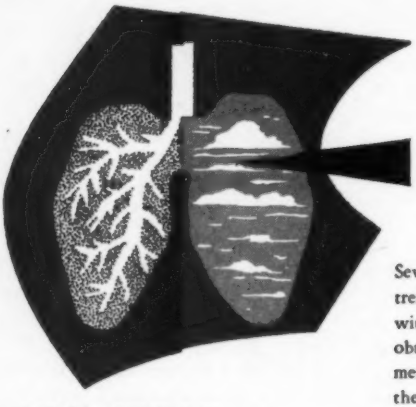
Why M.D.s Approve

This case typifies most of the reasons for the growing popularity among doctors, patients, and bankers of bank-sponsored medical time-payment plans. Where such services were comparatively rare ten or fifteen years ago, they're now offered in one form or another (not only by banks but also by loan companies and acceptance corporations) in nearly every good-sized U.S. city.

Together with a lesser number of doctor-sponsored medical credit bureaus, they've helped reduce many a physician's bookkeeping and collection headaches. As a result, some doctors have even found it feasible to absorb the credit costs themselves.

In the example cited, if the phy-

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*Highly Purified. ACTHAR® is The Armour Laboratories Brand of Adrenocorticotropic Hormone—ACTH (Corticotropin).

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PHYSIOLOGIC THERAPEUTICS THROUGH BIORESEARCH

sician had absorbed the cost, the patient would have signed a note for $150, the exact amount of the fee. And the bank would have deducted or "discounted" the $10.50 charge, as well as the $1.50 reserve, and paid the doctor $138.

Not for Indigents

From the patient's point of view, too, the bank plan is apt to be preferable to letting a bill ride or to paying the doctor in installments. Most patients realize that doctors aren't set up to handle credit conveniently; so the bank plan often seems more businesslike. And in an era of almost universal installment buying, there are sound precedents for financing medical care in this way.

Unfortunately, making money available for the doctor bill doesn't always solve *all* the patient's immediate financial problems. The hospital bill (when not covered by insurance), the anesthesiologist's fee, charges for nursing care—all these items and others may have to be reckoned with. And the doctor, of course, generally can't do much about them.

Sometimes, though, a loan for the amount of the doctor's fee makes it possible for the patient to pay these added charges. Or, if the patient is credit-worthy, the bank will often make an additional loan, in which the doctor *doesn't* participate, to cover the extra expense.

In this connection, bankers emphasize one caution: A loan is *not* the solution when the patient *can't afford* to pay for medical care. In that case, he can't afford to borrow, either.

The Usual Set-Up

Most of the bank-loan plans work basically like this:

1. The doctor participates in the transaction, at least to the extent of suggesting it to the patient;
2. The bank pays the doctor on completion of treatment; and
3. The patient repays the bank in installments.

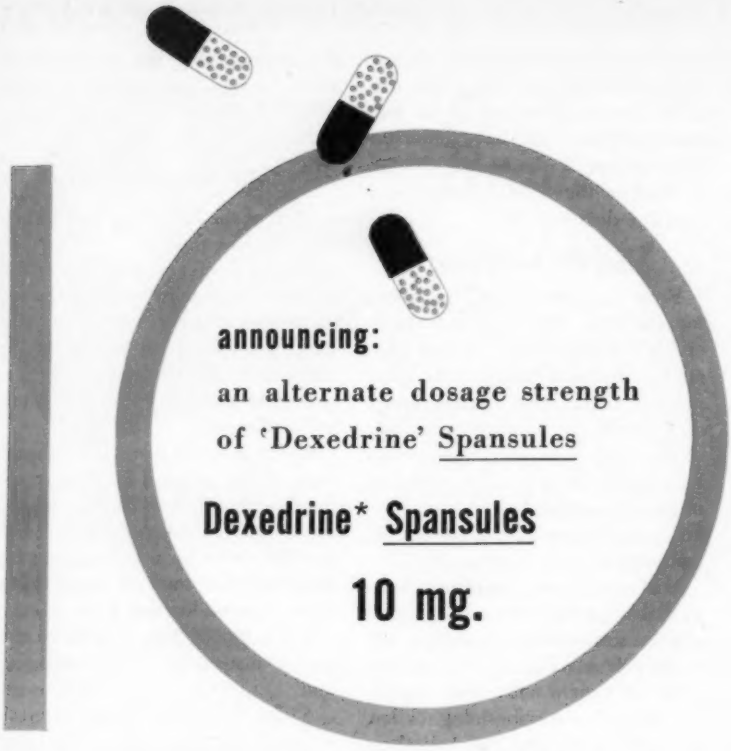
These medical loans are adaptations of the personal loans now offered by more than 12,000 commercial banks (as compared with 3,400 in 1940) and by other lending institutions. But medical loans differ from personal loans in that:

¶ The money goes directly to the doctor instead of to the borrower; and

¶ The doctor, in return, is often required to help protect the bank against possible losses.

If Patient Defaults

The second requirement hasn't always met with the approval of M.D.s. When it means merely that the bank holds back part of the money (usually 3 to 5 per cent) as a reserve, there are few complaints. But when the doctor is expected to sign a "full recourse" agreement—which means that if the bank can't collect from the borrower it can hold the doctor liable for money al-



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ready paid him—that's another story.

Many physicians feel they should be relieved of liability after they've helped a patient to a loan and have performed the needed medical service. It's the bank's business to decide whether the borrower is creditworthy, they point out; so if the bank makes a mistake, the doctor shouldn't be held responsible.

A prominent banking authority admits the logic of this argument. *But,* he says:

"If a bank is to accept borderline credit risks on medical loans, it must look to the doctor for relief when necessary. Otherwise, it may have to be selective to a degree that will hamper the effectiveness of the whole medical time-payment program."

Choice of Arrangements

Nevertheless, arrangements between banks and medical men have become increasingly flexible in recent years. Ten years ago, the banks generally insisted on the "full recourse" clause; it wasn't till they began to welcome non-recourse agreements that medical loans became big-volume business. And their losses have proved so small that many bankers are now willing to let the doctor choose whichever type of agreement he prefers.

Such flexibility has its advantages. Take, for instance, a doctor who has a non-recourse agreement with a bank. Now and then, he may decide voluntarily to make himself liable for a patient who otherwise couldn't meet the bank's credit requirements. And this may be a good business move.

Why? Because such a patient may be the type to ignore his doctor bill; but he'll probably take a more serious view of a bank debt.

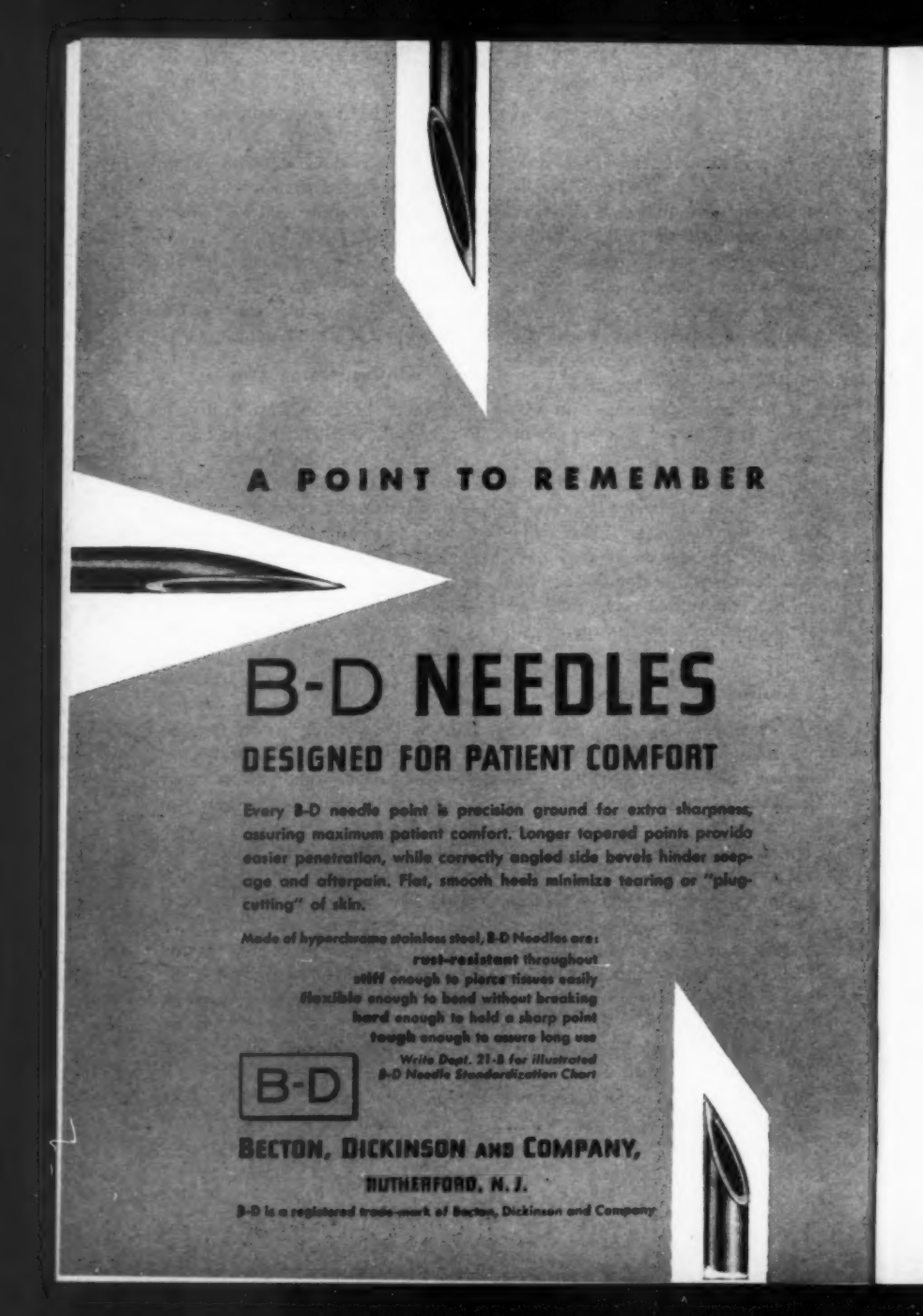
How to Start One

If your local bank hasn't already developed a medical time-payment plan, it may be glad to make the effort if you're interested. The procedure for setting up such a plan is simple. Typically, all that's needed is a signed agreement between you, as an individual physician, and the bank.

The agreement permits you to submit to the bank, for discount, patients' promissory notes. It settles the question of whether or not the bank will have full recourse to you in case of default. And it states the discount rate (normally 6 per cent) to be paid by the patient—or, if you prefer, by you.

In addition, it may specify the percentage of each note to be held in reserve against possible losses. If this money doesn't go into a pool account to which other doctors also contribute, it will probably be deposited in a collateral account in your name. When this account exceeds a certain level, the overflow will be released to you.

Once the agreement is in effect, the bank will supply you with the necessary forms. Thereafter, when


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a patient needs medical-care financing, he can make the application and sign the note in your office. And you'll get your payment directly from the bank.

Where Tact Is Needed

If you've had no previous dealings with this type of health financing, you'll be interested in these tips from doctors who have:

¶ Be tactful about prescribing bank credit. When your patient has made it clear that lack of ready cash is what stands between him and the treatment he needs, you can mention that you may be able to help him with his problem. Usually he'll welcome your suggestion.

¶ Be careful not to oversell a credit plan that the patient may not be able to afford. If, after you've encouraged him to apply for a loan, the bank turns him down as a bad risk, he's apt to resent your part in the fiasco. Or if the bank takes him on your say-so alone, your relationship with the bank may suffer if he defaults.

¶ Be willing to look at the picture from the banker's point of view. He'd much rather make a loan than not. When he decides against your patient, or asks you to shoulder some of the risk, he probably has sound reasons.

One Bank's Experience

Based on the experience of many banks in the field, medical time-payment plans generally have smooth sailing nowadays. But that wasn't always the case ten or fifteen years ago, when the idea was relatively new.

A large Midwestern bank, for example, found the going pretty rough when it started in the medical-loan field in the early 1940's. The doctors didn't like the full-recourse feature, which the bank at first tried to push exclusively. And they didn't like the effect on doctor-patient relations when the bank turned down a number of applicants as too risky.

Bank officials themselves were often unhappy. Doctors and dentists were referring many people for loans without troubling to find out whether they had any income. The



"It's all right with me if you want to see my father. But don't forget: He charges twenty bucks a visit!"



For the doctor: "Time Therapy"

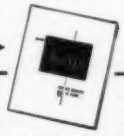
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bankers had a hard time making some of the doctors understand that obviously bad risks *had* to be rejected, and that doubtful applicants could be accepted only to the extent that the bank was protected by recourse agreements and reserve collateral.

A little education on both sides gradually solved the worst problems. The participating physicians learned to use judgment in referring patients to the bank. And the bank relaxed its insistence on full recourse, except in individual borderline cases.

Today, some eighty physicians—a majority of the medical community—and some twenty-five dentists participate in this bank's program. Most notes are payable in fifteen equal monthly installments, with larger loans spread over two years. There's a 6 per cent annual discount rate—or a $7.50 minimum charge for loans under $125.

The average loan made by the bank is $212.50. Of this amount, on a twelve-month loan, the doctor receives $201.87 after a 5 per cent reserve deduction—assuming, of course, that the patient pays the $12.75 discount.

Blue Triangle Plan

Among the several types of bank health-financing plans now operating, Massachusetts' Blue Triangle Plan is one of the most successful. Established in 1944 under the joint auspices of the state medical, dental, and banking associations, the plan is in effect at all commercial banks in Massachusetts that handle consumer loans.

Newspaper advertising by the banks and plaques in doctors' waiting rooms inform the public that any medical bill larger than $35 can be financed through the plan. Once a patient applies for credit and is accepted, the doctor collects his fee in full from the bank. And the patient gets a better-than-usual break in that he pays 6 per cent interest *only on the outstanding balance* of his loan, which is trimmed down by monthly payments.

A Denver bank offers a slight variation on the Massachusetts pattern. Instead of asking the patient to fill out forms in the office, the doctor gives him a card of introduction to the bank. There, if his credit is good, the patient signs a note for the amount of the doctor's fee plus charges of $7.20 per $100. The patient is then given a cashier's check payable to the doctor.

'Free' Loan Plan

Wherever such plans function, they work according to varying sets of rules. But there's a common denominator to all of them: They exist in order to help the doctor help his patients meet their bills.

One such scheme is remarkably liberal from the patient's point of view: Working independently of banks, 1,200 Pittsburgh medical men have set up a "Budget-for-

For Allergies That Are

"Epidermis-Deep"

Quick relief is best achieved with a combination of a local anesthetic and an antihistaminic. Lotion or Cream 'Histadyl' and 'Surfacaine,' applied to the affected parts three or four times a day, usually affords prompt and lasting comfort.

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Prescribe the lotion for a weeping dermatitis

caused by poison ivy, eczema, insect bites, or heat rash . . . when, in addition to antihistaminic and anesthetic action, the drying effect of zinc oxide and calamine is desired.



Prescribe the cream for a dry dermatitis

resulting from contact with drugs, chemicals, paints, plastics, or clothing and from insect bites or severe sunburn. A fragrant vanishing cream.

Histadyl and Surfacaine

(THENYLPYRAMINE, LILLY) (CYCLOMETHYCAINE, LILLY)

Health" plan that provides time-payment facilities for nearly 20,000 credit-worthy patients *at no extra cost*. Credit charges are paid by the doctors and dentists at the rate of 6 per cent of the fee plus a $3 service charge.

The patient is given a card of introduction to Pittsburgh's Medical Bureau, which handles the service.

If the applicant is regularly employed, can afford reasonable payments, and has an acceptable credit record, he gets his loan. And the doctor gets his fee, minus the service charge and percentage, as soon as he completes his treatment.

Elsewhere, reports indicate that more and more doctors have found it worth while to shoulder the credit charges on medical-care loans. The gain in good will, they're convinced, more than offsets the comparatively slight monetary loss.

Nineteen per cent of all U.S. families are in debt to their doctors, hospitals, or dentists, according to the Federal Reserve Board's latest Survey of Consumer Finance. And the great majority of Americans still aren't covered by Blue Shield or other medical prepay plans. So the banks' time-payment services are finding favor with increasing numbers of doctors and patients.

Opposing Arguments

But not with all of them. Some physicians—and some patients—feel that collaboration between doctors and banks in this field introduces an unwholesome mercenary element into the practice of medicine. Other objections are cited, too. Among them:

¶ When you set a sizable fee and offer to help a patient borrow to pay it, he may suspect that you're more interested in the money than in his ailment.

¶ When your patient has saddled himself with a medical installment loan that will ride him for a year or more, you may have lost him for that long. He may even jeopardize his health rather than incur additional medical expense in the interim.

¶ A responsible patient can—and should—make his own borrowing arrangements privately. An irresponsible one shouldn't—and probably can't—borrow at all. Either way, you as a doctor have no business meddling with his financial future—unless, of course, he asks your help or advice.

Answers to Objections

But physicians who *approve* of health-financing by banks have answers to these criticisms. They say, for example, that:

¶ In our new credit-based economy, financing doctor bills is as logical as financing the purchase of a car or a refrigerator. But many people of modest income may never know that they can pay for medical treatment this way unless you tell them.

¶ The tactful suggestion of a bank



she's
rheumatic
...but
comfortable

since her doctor prescribed

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MEPHOSAL *enables rheumatic patients to go about daily tasks in greater comfort.*

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supplied: Tablets in bottles of 50, 100 and 500; Elixir, 8 oz. and 1 pint.

MEPHOSAL contains	TABLETS	ELIXIR
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Sodium Salicylate	125 mg.	400 mg.
Homatropine Methylbromide	1.25 mg. per tablet	2.5 mg. per teaspoonful

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loan, when you feel it's timely, is more likely to improve than to hurt your relations with a patient. Far from resenting it, the patient with money problems is usually grateful for any reasonable solution. And once the transaction is completed, you'll never need to go through the collection routines that so often *do* alienate patients.

¶ Your efficiency is increased and your overhead cut when the bank pays your fee and takes the responsibility for collections. Sometimes you can reduce your bookkeeping and billing even further by consolidating a patient's past-due bill with your fee for a new treatment.

¶ By telling people how they can pay for needed medical care that otherwise might have to be postponed, you're contributing to the better health of the community.

Says one banker:

"Financing health services has become a normal, constructive, and sound credit procedure. Most lenders look favorably on this type of loan. Speaking for myself, I don't know of any better purpose for borrowing on an installment basis than to pay medical bills." END

Silent Treatment

● Shortly after I had left Paris and settled in a Normandy village, I was called out to see a man who had been found on the railway track early in the morning. It was supposed that, having missed his regular local train, he had taken an express train and had been hurt while jumping off at the village station.

Even for me, a beginner, it was bound to be an easy case. The patient might die, but what else can you expect if you jump from a fast-moving train? Anyhow, the diagnosis would be simple; and I would leave the impression that the new doctor was a first-class physician, efficient and clever.

When I arrived, I saw exactly what I'd expected. My patient was comatose. There were scratches on his face and hands; he wasn't going to last long.

But then came some surprises: The knee jerks were normal; and, still more disquieting, so were the plantar reflexes. I began to wonder whether it would turn out to be such a simple case after all. [MORE→

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Then I realized that the patient was not entirely comatose. When pinched hard, he would grunt and open his eyes. As for objective signs of brain concussion, cerebral hemorrhage, or anything of that sort, there were none whatever.

My hopes began to deflate as I puzzled over this; it was harder than I'd thought to be a clever young doctor.

I needed time. So I said I'd return later for another look at the patient. Then I rushed back to my office and feverishly looked through my books for a clue. I found none.

Depressed but hoping that the situation would have taken a turn for the better—or worse—I returned to my patient. He was exactly as I had first seen him: not quite comatose, able to open his eyes occasionally and look around, but still not able to speak.

My hopes were almost utterly crushed now. But hoping to salvage some crumb of reputation, I decided to attempt a lumbar puncture. I went out to my car for my needle and, as I did, I bumped into a villager.

"How's Henri?" he asked.

"I'm not yet sure," I admitted. "By the way, what sort of man is he?"

"Well, Doctor," the villager said with a shrug, "he doesn't seem too smart. But then, I guess it's because he's deaf and dumb."

—GABRIEL MOUCHOT, M.D.



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Should You Buy Savings and Loan Shares?

They offer a pretty good rate of interest; but they're riskier than bank deposits, and you can't always cash them in when you want to

By Robert B. Temple

● An officer of a New Jersey bank tells of an out-of-state doctor who came to him for a short-term loan. The doctor confidently offered his passbook from a Southern savings and loan association as security; yet, after investigation, the banker turned down the application.

"But why?" asked the startled physician. "Is there any better security than money in the bank?"

He was astonished when the banker explained that his savings weren't so liquid as he'd thought—and that they weren't, therefore, good collateral for a short-term loan. Like many investors, the doctor hadn't realized that savings and loan associations needn't pay up on demand. Reason: They're *not* banks.

They're at least worth looking into, on the other hand,

¶ If you want higher-than-bank interest;

¶ If you fully understand that you're making an investment, not depositing your money in a bank; and

¶ If you're willing to take the risk of putting your funds into the mortgage market.

The prime purpose of savings and loan associations is to lend money to people who want to finance homes. So such associations would be in a bad way if the country's economy ever sagged to a point where many property

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"The most satisfactory antispasmodic for use in spastic dysmenorrhea is, in my experience, 'Benzedrine' Sulfate . . ."

Janney, J.C.: Medical Gynecology, ed. 2, Philadelphia, W.B. Saunders Co., 1950, p. 365.

'Edrisal' relieves pain

" 'Edrisal' was more effective than any other analgesic previously used . . ."

Wells, R.L.: M. Ann. District of Columbia *20*:360, 1951.

'Edrisal' relieves depression

"Mental depression was always relieved."

Hindes, H.J.: Indust. Med. *15*:262.

Each 'Edrisal' tablet contains: Benzedrine* Sulfate (racemic amphetamine sulfate, S.K.F.), 2½ mg.; acetylsalicylic acid, 2½ gr.; and phenacetin, 2½ gr. *Recommended dose:* 2 tablets. *Prescription size:* Bottles of 50 tablets.

For severe or intense pain, 'Edrisal with Codeine ¼ gr.' is obviously preferable—even to 'Edrisal'.

Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off.



owners couldn't meet their mortgage payments.

In this event, if you were an investor, you might have to wait a long time to get your money out. But the Government insures individual investments (up to $10,000) in such associations, as it does deposits in banks.

High Returns

Savings and loan investments have one obvious attraction: They yield comparatively good returns. With about 85 per cent of their assets sunk in well-paying mortgages, the savings and loan associations can afford to pay investors as much as 3½ per cent on their money, in some cases. This compares more than favorably with the 1 per cent of commercial banks and the 2½ per cent or so of mutual savings banks.

As a result, growing numbers of physicians—and other people—have been investing in the associations in recent years. Since 1945, their assets have jumped 158 per cent, as against a 47 per cent asset gain for mutual savings banks and a 34 per cent increase for commercial banks.

Bank Services

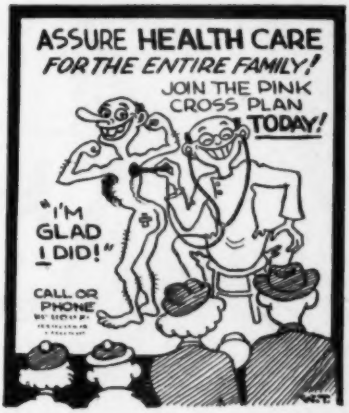
There are other reasons why you might want to put some money into one of the associations:

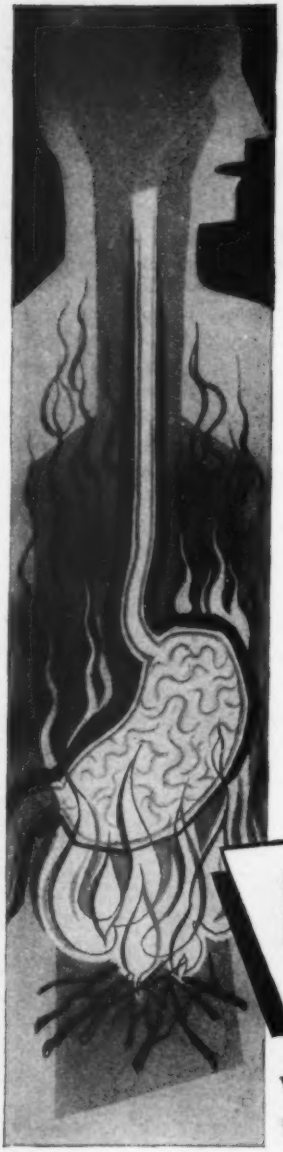
¶ They offer most of the services of a savings bank: money orders, travelers' checks, foreign remittances, and so on.

¶ They may be more convenient to your office than are any of the mutual savings banks. (The country has 6,000 savings and loan associations, located in every state; but only 529 mutual savings banks, located in seventeen states—mostly in the East.)

But don't make the mistake of confusing them—and the way they work—with banks. Says the vice president of one of New York's largest associations: "We've always paid on demand. We figure we'd be out of business tomorrow if we didn't." But he adds that in other states that's not always the case.

A bank official puts it this way: "The purchase of savings and loan shares is an investment. Money in the bank is a deposit. An investment involves risk. That means it can be tied up for a while, if not lost. A deposit, on the other hand, can be withdrawn at any time." END





when the patient complains of a gastric bonfire

. . . usually, an antacid is indicated — but remember that most antacids stop protein digestion. To arrest acid action, and maintain protein digestion,* prescribe AL-CAROID, the antacid digestant. Here is a balanced combination of four proved antacids, plus the potent proteolytic enzyme, "Caroid." AL-CAROID effectively counters gastric hyperacidity AND maintains the digestion and assimilation of proteins.

*"Caroid" increases the digestion and assimilation of proteins up to 15.5% above the normal. Tainter, M. L., et al: Papain, Ann. New York Acad. Sc. 54:143-296 (May) 1951, p. 295.

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Backing Out of a Real Estate Deal Is Risky Business

Better think twice, warns this lawyer, before listing a property with a broker. For if he finds a buyer and you change your mind, you may still have to pay him his commission

By Joseph Berman, LL.B.

● A doctor I know put his home up for sale last fall—partly to get a line on its market value, and partly because he thought he might sell it *if* he could get a high enough price.

Before it had been listed two months, his broker found a prospective buyer. But meanwhile the physician had decided to hold on.

"We've lived here a long time," he explained. "And I guess it's foolish, at my age, to go to all the trouble of resettling." So he turned down the offer, even though it was a good one.

What the M.D. didn't know, unfortunately, was that as soon as the real estate agent turned up with a buyer willing and able to pay his price, a broker's fee was due. At the broker's insistence, he soon learned this fact. And the lesson cost him 5 per cent of the valuation he had put on his place.

So if you've been thinking of listing some property for sale, be sure you really *want* to sell it before you give it to an agent. You're not likely to find the law on your side if, having changed your mind, you refuse to pay the

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FERROLIP Tablets:
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agent his commission once he's earned it.

Such backing down is construed as a breach of contract. And in such a case, even if you have a rock-bound, apparently all-inclusive agreement with the broker, the law won't necessarily protect you.

Consider, for example, a case that was tried, not long ago, by the New York Appellate Division. The agreement between broker and property owner read: "Should the deal not be consummated . . . for any reason whatsoever, no commissions shall be considered earned." Yet the court ruled that the owner was obligated to pay, since he had "capriciously" refused to sell.

Reason for the Law

The courts try to protect each party to an agreement from being put "at the mercy" of the other. And, in the eyes of the law, you're taking unfair advantage of your broker when you arbitrarily change your mind after he's made a deal for you. Result: Unless the broker gives you a *specific written statement* permitting you to back out of the deal at any time, he can generally collect his fee if he decides to take the case to court.

Not all jurists have identical opinions on the matter, of course; and not all states have identical laws. Yet the basic concept of protection for both real estate broker and property owner holds true nearly everywhere. END

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who have Seborrheic Dermatitis of the scalp . . . prescribe

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Effective control of scaling . . . prompt relief of itching and burning . . . extreme simplicity of use . . . this is the story of SELSUN Sulfide Suspension, Abbott's new *prescription-only* product for the management of seborrheic dermatitis of the scalp. Clinical investigators who treated 400 patients[1, 2, 3] found SELSUN effective in 92 to 95 percent of cases of mild seborrhea (common dandruff), and in 81 to 87 percent of all cases of seborrheic dermatitis.

SELSUN was successful in many cases that had failed to respond to other recognized methods of treatment. Optimum results were obtained in four to eight weeks, although itching and burning stopped after the second or third application in most cases. After the initial treatment period, a single application keeps the scalp free of scales for one to four weeks.



SELSUN is convenient to use, because it is simply applied while washing the hair and then rinsed out. It thus leaves the hair clean and odorless, and obviates the problem of stains on clothing and linens. Specific research on toxicity[1, 2] shows there are no harmful effects from external use of SELSUN as recommended. Supplied by pharmacies in 4-fluidounce bottles, with tear-off labels. Dispensed only on a physician's prescription. Abbott

References:

1. Slinger, W. N., and Hubbard, D. M. (1951), Arch. Dermat. & Syph., 64:41, July.
2. Slepyan, A. H. (1952), Ibid., 65:228, February.
3. Ruch, D. M. (1951), Communication to Abbott Laboratories.

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SULFIDE *Suspension*

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D



MEDICAL MOMENTS . . . *VACATION?*

"Too bad about that fish, Doc . . . might have run twenty-twenty-six pounds, but to get back to my sister-in-law's stomach trouble . . . after the operation . . ."

You probably have your share of local irritants that you've just got to tolerate. Like chronic complainers, seekers of free advice . . . and frustrated diagnosticians like the one pictured above.

But there are certain other irritations you *don't* have to put up with. One of them is *hospital hands;* hands that get tender and sore from frequent and energetic scrubbings. Not when it's so easy and so pleasant to keep them smooth and comfortable with Noxzema. It's delightfully soothing—helps heal the tiny cracks and cuts in chapped skin. And Noxzema is greaseless, too. No greasy mess on your hands.

Here's another good tip. Rub a little Noxzema on your feet some night when they're hot and tired after a hard day. See how cool and refreshing it feels, how much better *you* feel afterwards!

For Your Information

Regular Noxzema Skin Cream is a modernization of Carron Oil, fortified by adding Camphor, Menthol, Oil of Cloves and less than ½% of Phenol in a greaseless, solidified emulsion. Its reaction is almost neutral—the pH value being 7.4.

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effective
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conception control
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Also available: Ortho® White Kit with
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Partnership Practice: In Case of Dissolution

[CONTINUED FROM 157]

estate . . . his percentage share of all receivables outstanding at the date of his death . . . which are collected within two years after his death . . . Such payments shall be made not less often than quarterly."

Throughout this series, we've been talking as if dissolution automatically followed one partner's death. But it doesn't have to. Witness these excerpts from an unusual agreement between three Midwestern practitioners:

"In the event any partner dies, this firm shall not be terminated . . . The surviving partners shall pay to the deceased's estate an additional $25 for the exclusive right to use his name . . . plus the following proportion of the partnership's net income for a period of three years:

¶ "If first party dies, 35 per cent.

¶ "If second party dies, 15 per cent.

¶ "If third party dies, 10 per cent.

"The deceased's estate shall continue as a member of the partnership for three years; but such estate shall have no voice in the management of the partnership, except to determine the proper share due to said estate . . . "

Thus—if the doctors want it—the income security that a partnership affords can be projected well beyond one partner's death. END



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Anywhere . . .

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Whenever distressing

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Wherever the patient

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Manufacturing Chemists

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Medical Veterans Organize

[CONTINUED FROM 108]

duced its ratio of doctors to soldiers. And the Defense Department has established a commission of laymen to investigate the entire question of dependent care.

Is the new society responsible? "No," says the Pentagon. "No prodding was necessary." "No," says the A.M.A. "We've been shooting at the same target."

But it's a fact, too, Dr. Walsh points out, that before the M.V.S. got into the picture, the Pentagon had shown little real interest in drafting most Priority 3 physicians. Only since the emergence of an active national association of doctor-veterans has the Pentagon's attitude changed.

What of the future? If the doctor draft again becomes a dead issue, won't the national M.V.S. gradually disappear from the scene, just as the local veterans' societies did in 1947?

The question, when I asked it, disturbed Walsh. "If we have no purpose in staying alive,'" he said, "we'll die. But I think there are important functions we can perform."

One of these, he believes, is to help M.D.s returning from Korea, so that "they don't go through what we did in 1946."

He recalls that many returning doctors couldn't get hospital privileges at that time—because, as some hospitals put it, "You haven't sent us any patients lately." And the civilian practitioners, Walsh adds, "had all the office space tied up."

He tells of one case concerning two doctors—say Jones and Brown. Both were just getting established in practice when the war began. Jones, the older of the two, had an office and permitted Brown to share it. Then, in 1942, Jones went into service, while Brown was rejected. Four years later, Jones returned to find that Brown held the lease on the office and "didn't have any room" for Jones.

"We don't want that sort of thing to happen to the veterans of Korea," says Walsh. "And by staying organized, both at the national and local levels, we can make sure it doesn't."

The M.V.S. has other reasons for existing, too, according to leaders of the society. Here's what they say:

1. "We've all been under fire. We've treated mass casualties. We don't panic. So we should obviously have a major part in planning medicine's role in civil defense.

2. "We're close to military and veterans' affairs. There's no organization better qualified to handle these matters for American doctors.

3. "Decisions made by the A.M.A. today will affect us tomorrow. So the M.V.S. can and should be an influence in medicine's council halls. We're medicine's young blood. We can be of benefit to the profession—and to America." END

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The 100 patients in a carefully controlled evaluation of Vagisol in trichomoniasis ranged from 10 years to 80 years in age. Culture-established cure was shown in 98 of these patients, including every age group.



*Shaw, H. N.; Henriksen, E.; Kessel, J. F., and Thompson, C. F.: Clinical and Laboratory Evaluation of "Vagisol" in the Treatment of Trichomonas Vaginalis Vaginitis, Western J. of Surg., Obst. & Gynec. *60*:563 (Nov.) 1952.



In Trichomonas Vaginitis

Two important advantages of Vagisol in trichomonas vaginitis were established in the study cited:

Remarkably rapid relief from the distressing symptoms: pruritus, burning, suprapubic pain, dyspareunia, dysuria. The patients were symptom-free in 2.15 mean patient days. The controls, treated with another trichomonacide, required 6.75 days.

A 98% cure rate, in ⅓ to ⅓ the time required by the control group. Vagisol produced culture-demonstrable cures for 72% of the patients in 18 days, for 22% in 36 days, and for 4% in 54 days. Of the controls, 25% required 56 days of therapy, 42.5% 84 days, and 20% required 112 days.

Vagisol proved equally effective in every age group—in childhood, during the reproductive years, and after the menopause.

Though quickly relieved of their discomfort, patients cooperated and remained on Vagisol therapy.

Vagisol Supposítabs, supplied in bottles of 36, are odorless and nonstaining. Each Supposítab contains:

Phenylmercuric Acetate	3.0 mg.
Tyrothricin	0.5 mg.
Succinic Acid	12.5 mg.
Papain	25.0 mg.
Sodium Lauryl Sulfate	3.0 mg.
Lactose	0.75 Gm.

Vagisol is available on prescription through any pharmacy. For detailed literature, clinical test samples, and patient instruction leaflets, physicians are invited to write to Smith-Dorsey, Lincoln, Nebraska (a Division of The Wander Company).



VAGISOL

A DORSEY PREPARATION

The Journal of the American Dietetic Association, October, 1951, (1) published important findings that emphasized the superiority of reconstituted MINUTE MAID Fresh-Frozen Orange Juice over home-squeezed juice of the same type oranges, in three respects:

(1) *Average levels of ascorbic acid significantly higher:* Obviously, this advantage of MINUTE MAID, observed in samples tested, is susceptible to variation, from season to season, as crops differ. It should be emphasized, however, that, penny for penny and year after year, the lower-priced MINUTE MAID offers *more* ascorbic acid than home-squeezed orange juice.

(2) *Peel oil content significantly lower:* Samples of orange juice, home-squeezed by typical housewives, showed that contents of peel oil, a cause of allergic response and poor tolerance, especially in infants, (2) were up to 700% higher than in MINUTE MAID!

(3) *Bacterial counts dramatically lower:* Bacterial counts were found to be as high as 350,000 per ml. in home-squeezed juice, but were uniformly low in MINUTE MAID.

Since publication of the above, more and more physicians are recommending MINUTE MAID in place of home-squeezed orange juice. And now comes more evidence in favor of MINUTE MAID . . .

New Assays Reaffirm Dietary Advantages of Minute Maid Fresh-Frozen Orange Juice on a Cost Basis

The Journal of the American Dietetic Association, November, 1952, (3) carries a second report comparing MINUTE MAID Fresh-Frozen Orange Juice and home-squeezed juice of the same type oranges. In this latest study, each sample was analyzed separately:

Although the results are again susceptible to variation according to crop and year, Fresh-Frozen MINUTE MAID was equal to the home-squeezed juice in the samples tested for the largest number of components listed; and in the mean values for iodine, manganese, potassium, Vitamin A (4) and Vitamin B_{12}, MINUTE MAID showed appreciably *higher* values.

TABLE: *Mean Values in Samples Tested*

COMPONENT	UNITS	MINUTE MAID FRESH-FROZEN ORANGE JUICE	HOME-SQUEEZED ORANGE JUICE
Betaine	mg./100 ml.	49	46
Biotin	mcg./100 ml.	0.26	0.26
Choline	mg./100 ml.	12	12
Cobalt	mcg./100 ml.	74	67
Folic acid	mcg./100 ml.	2.2	2.2
Iodine	mcg./100 ml.	0.24	0.21
Manganese	mcg./100 ml.	33	18
Nitrogen			
Total	mg./100 ml.	104	79
Amino	mg./100 ml.	22	22
Volatile	mg./100 ml.	8	7
Non-volatile	mg./100 ml.	96	72
Pantothenic acid	mcg./100 ml.	146	145
Para-amino-benzoic acid	mcg./100 ml.	4	4
Phosphorus	mg./100 ml.	19	18
Potassium	mg./100 ml.	380	290
Riboflavin	mcg./100 ml.	18	17
Tocopherols	mg./100 ml.	107	104
Vitamin A	mcg./100 ml.	19	16
Thiamine	mcg./100 ml.	87	83
Vitamin B_{12}	mcg./100 ml.	0.0022	0.0012

SUMMARY

These new findings help enlarge professional knowledge of the nutrient constituents of orange juice in general and add fresh evidence that, on a cost basis, MINUTE MAID Fresh-Frozen Orange Juice offers not only *more* Vitamin C, but also *more* of all the other vitamins and minerals listed.

Taken in conjunction with the previously published findings, this should confirm the choice of physicians who recommend MINUTE MAID in place of home-squeezed orange juice.

REFERENCES:

(1) Rakieten, M. L., *et al.*, Journal of the American Dietetic Association, October, 1951.

(2) Joslin, C. L., and Bradley, J. E., Journal of Pediatrics, Vol. 39, No. 3, pp. 325-329 (1951).

(3) Rakieten, M. L., *et al.*, Journal of the American Dietetic Association, November, 1952.

(4) Assn. Off. Agric. Chemists: Methods of Analysis, 7th ed. Wash.: Assn. Off. Agric. Chemists, 1950.

Reference #3 still available in reprint form.



MINUTE MAID CORPORATION

488 MADISON AVENUE, NEW YORK 22, NEW YORK

Wallace R. Roy, Ph.D., Director of Research

A 'Magic' Plan for Getting Rural Doctors

[CONTINUED FROM 134]

after rushing emergency cases to the hospital at Lynchburg. But he managed to set up the new Huddleston Clinic, with the help of Miss Josephine Howell—a neighbor who acted as his secretary and nurse. He kept office hours from 8:30 to 5, and from 7 to 9 three evenings a week. And since there's no drugstore in the community, he stocked his own pharmacy and compounded his own prescriptions.

At the end of the month, Mrs. Tucker and the baby joined him. This was the occasion for a gala public reception, arranged by the Otter Grange and attended by townsfolk and farmers from the remotest corners of the community.

Rewarding Work

Six months later, it was possible to see with some clarity just what had been accomplished by this particular example of the Virginia Council's wholesale matchmaking.

When spring arrived in Huddleston, Dr. Tucker—who had been a junior deacon of the Baptist Church back home in Richmond—still hadn't been able to get to the Mentow Baptist Church more than four or five times. He had wistful hopes of doing a little hunting and fishing in the surrounding hills; but so far he'd had no time for such excursions.

Mrs. Tucker, whom he had married when he entered medical school, complained that she used to see more of him in his student days—even though he had worked for a Richmond newspaper when not attending classes or studying.

But Dr. Tucker was seeing from 250 to 300 patients a week at the clinic, at their scattered homes, and at the hospital at Lynchburg. And he knew that he was doing a necessary job and that his patients valued his services.

It's a Challenge

"We're staying," was the way he summed it up, not long ago. "We came here knowing there'd be hard work and middle-of-the-night calls; and they haven't been any worse than we expected. We like the community, and apparently the community likes us. We know we're *needed*, and we're beginning to feel that we *belong*, and there's a lot of satisfaction in those things. I wouldn't dream of trading the challenge of Huddleston for the scramble of building a city practice, or even for the comparative ease of a city practice once it's built."

There's reason to believe, also, that the pressure in Huddleston will ease as time goes on. Thanks to another campaign sparked by the Virginia Council, a new Hill-Burton hospital is going up this year in Bedford County. And eventually, Tuck-

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er is convinced, there'll be another doctor to share his burdens in or near Huddleston.

As it is, he has excellent cooperation from the other physicians of the area, considering how busy and distant they are. Included among them, incidentally, are two of his medical school classmates, Drs. Tom and Eileen Jennings, of Bedford—a husband-and-wife team who also found their location through the Virginia Council's placement service.

21 Placed in 1952

While the story of Dr. Tucker is a singularly revealing example of what the placement service is accomplishing, it's by no means the only one. In 1952, twenty-one doctors were placed in nineteen rural communities (two of the areas got two doctors each). During the year, eighty-five communities asked the Council for help; and Director Fisher visited thirty-nine of them and helped launch programs to attract doctors. Judging from past results, most of these programs will probably bear fruit in a year or two.

Only lately has the placement service become the Council's major activity. Originally, its efforts were directed mainly toward campaigns that have resulted in the completion of thirty-four new rural hospitals and thirteen new rural health centers throughout the state.

The Virginia Council on Health and Medical Care was created in 1946, when Dr. H. B. Mulholland, then president of the Virginia medical society, called together the state's official and voluntary health groups, in order to plan for improved rural health facilities. Since then the Council has operated as a voluntary coordinating group on a $19,000-a-year budget subscribed by fifty-four state-wide and 120 local organizations, as well as by hospitals, industry, and individuals.

The physician placement service was set up in 1950, after a survey showed that 40 per cent of Virginia's rural doctors had been in practice thirty years or more, and that many of them were well over 70. In thirty-three of the state's 100 counties, thousands of people were apparently without *any* kind of medical care.

"And younger men were shying away from country practice," says Fisher. "Our rural population was faced with a terrifying problem that was growing steadily worse."

Reversing the trend wasn't easy. He began by gathering information on doctor-needs through such organizations as the State Grange and the League of Virginia Counties. And through the state and county medical societies and Virginia's two medical schools, he sought to interest doctors and students in rural practice.

"Right at the beginning, we saw that we'd have to make two distinct approaches to the problem," he relates. "If we sent doctors to towns that couldn't support and wouldn't appreciate them, no one would be


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memory needs
a friend...



The dial at left might never spin, were it not for carefully organized directories which spare our brains the task of remembering telephone numbers.

Organized information that's easy to use is equally indispensable to the practicing physician; especially in recent years, as advances in pharmaceutical research have increased greatly the number and variety of prescription drugs available.

Since 1947, doctors have solved this medical memory problem by referring more and more frequently to PHYSICIANS' DESK REFERENCE — the unique annual directory of pharmaceutical specialties that is kept within easy reach by the majority of physicians in the United States.

PDR

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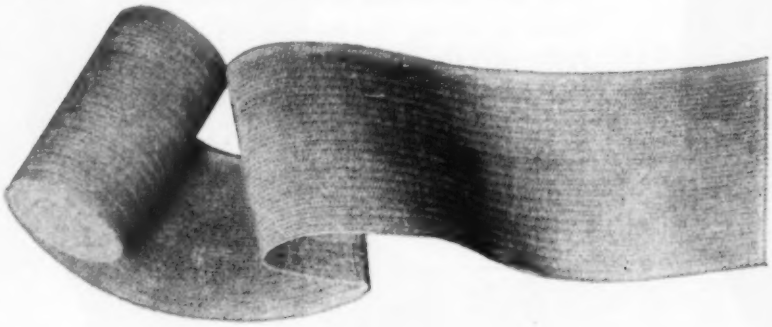
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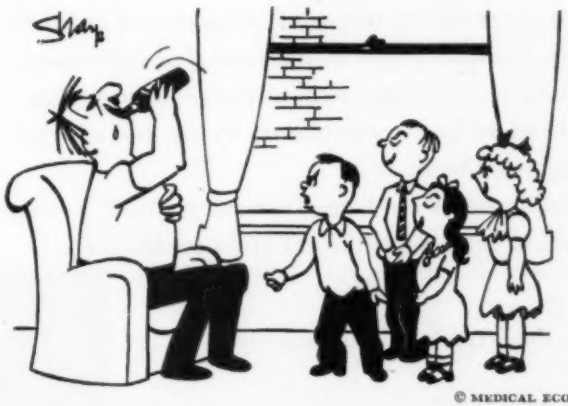
"On the other hand, we realized we'd have to give the doctors and students every possible encouragement to take up rural practice. So we had to be prepared to point out the very real advantages and satisfactions of such work, as compared with practice in already overcrowded cities."

The program can hardly be said to have started with a bang. From its inception through 1951, the service worked with 133 doctors and ninety-one communities—and succeeded in placing only thirteen doctors. However, as in Huddleston, a good many of the local programs begun then bore fruit later.

Meanwhile, sound plans for the future were being laid. A number of rural scholarships were established at Virginia's two medical schools, each worth $1,000 a year. Thus, because an applicant must agree to give a year to rural practice for each year of subsidized study, some fifty new doctors a year will soon be moving into the country.

And the schools have fully cooperated. On their own, for instance, they maintain a program of rotating interneships, whereby each interne at the two teaching centers spends two to three months in one of six rural hospitals. Through this contact with the realities of rural practice, many of the young men may well be drawn to it later on.

Each year the Council gets in touch with junior and senior students at the Virginia schools, as well as with senior students in neighbor-



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"Hurry up with that cough medicine, Pop. We wanna play spin the bottle!"

Triple Sulfas | diazine merazine methazine solve

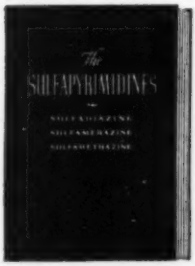
Without recourse to the use of alkali, adequate and effective sulfonamide therapy can now be administered without risk of crystalluria, by the use of triple sulfapyrimidines. Since the constituents of this mixture dissolve independently, the three pyrimidines, all therapeutically potent, have been combined in one preparation. Even with large doses, none of the individual drugs exceeds the concentration at which it is soluble so long as normal water intake is maintained.

No single sulfonamide of comparable potency equals the solubility of triple sulfapyrimidines in urine at the acidity frequently encountered in febrile patients, namely, *p*H 5 and less. Full sulfonamide anti-bacterial therapy without danger of crystalluria is therefore best accomplished by the use of triple sulfapyrimidines.

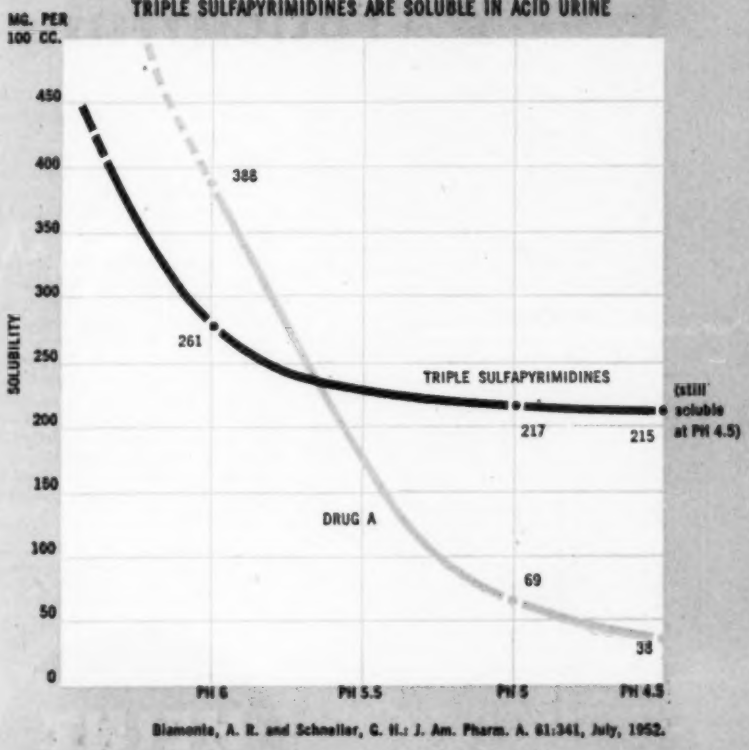
Triple sulfas are being increasingly used in conjunction with penicillin and other antibiotics.

Have you received your copy of
THE SULFAPYRIMIDINES?

This monograph, beautifully leather-bound, may be requested from the detail men of any ethical house calling on you; or, if you prefer, we will send you a copy immediately upon request on your professional stationery.



the problem of Crystalluria



Diamonte, A. R. and Schneller, G. H.: J. Am. Pharm. A. 41:341, July, 1952.

This advertisement is presented on behalf of the ethical pharmaceutical manufacturers of sulfapyrimidine preparations by

CALCO CHEMICAL DIVISION

American Cyanamid Company Bound Brook, New Jersey

PEDIATRICS BULLETIN

Prepared In The Interests Of The Profession By The Pediatrics Consultant Staff Of H. J. Heinz Company

Sanitation and Increase of **POLIOMYELITIS**

PARADOXICALLY, we have found that there is evidence that better hygiene may bring about increased risk of disease. In this country "Infantile Paralysis" is no longer infantile, but occurs most frequently in older children or young adults. It is clear that there is an inverse relationship between paralytic disease and the finding of circulating antibodies to the poliomyelitis virus.

● **In Egypt,** where poliomyelitis is still an infantile paralysis and few older children contract it, 90% of the children already possess antibodies at the age of three years.



● **In this country** a much lower percent of children or adults have demonstrable antibodies. If we measure prevalence of infection by presence of circulating antibodies, it is evident that subclinical infection in infancy is much more frequent in Egypt than in this country.

● **Here, in the United States,** paralysis seems a less likely consequence of infection by the poliomyelitis virus in infancy than later in life. The failure of our infants to become infected with the virus seems to be related to the increased incidence of poliomyelitis in an older population. It is clear that with this disease, as it is with diphtheria, improved sanitation necessitates a greater dependence on the development and use of artificial immunizing techniques.

NOTE: These bulletins are designed to help disseminate modern pediatrics knowledge to the general medical profession and will appear monthly in Medical Economics.

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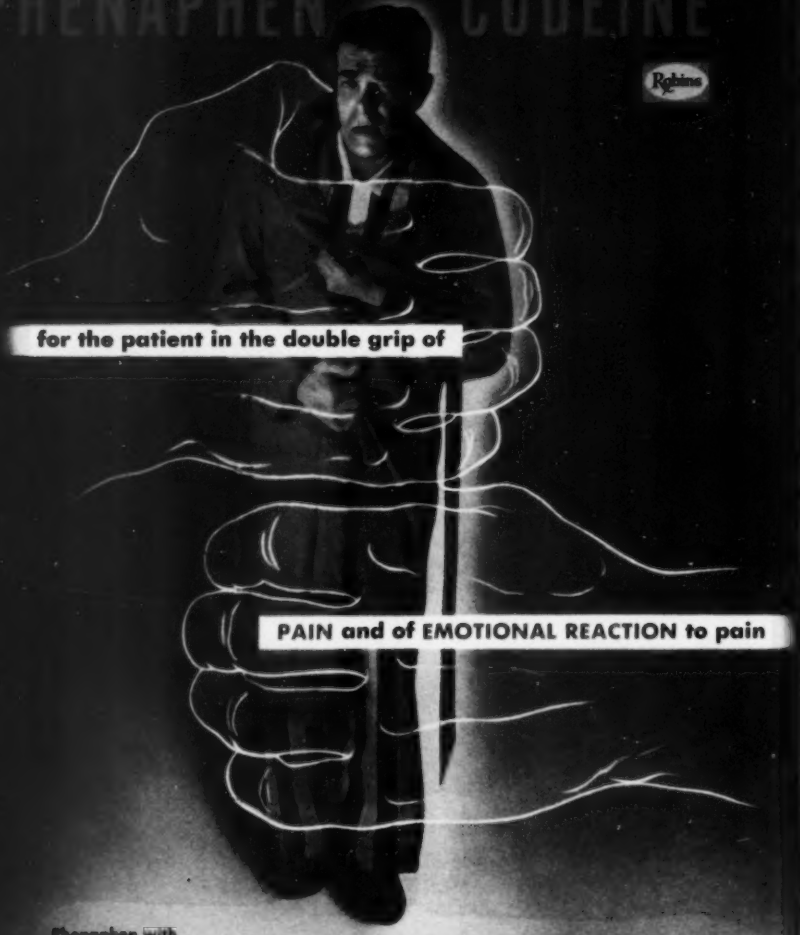
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Phenaphen with Codeine Phosphate ¼ Gr. (Phenaphen No. 2)

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ing states; and it invites them to make use of the placement service. Internes who come to Virginia from other states are also contacted. And Virginia graduates and internes who leave the state are followed by letters urging them to return.

For example, Dr. James D. Wilson, a 1951 graduate of the University of Virginia medical school, was interning in Oklahoma when he received the Council's list of doctor-shy communities. Now he and his family are occupying a community-provided bungalow in Virginia's historic old Charlotte Court House, the center of a rural area whose 5,000 people were without a physician for five years. He has office space in the local Red Cross building; and simultaneously with his arrival the weekly newspaper announced:

"As a result of a doctor's locating at Charlotte Court House, B. D. Parsons' Drugstore has opened again after being closed for three years. It was good news to Mr. Parsons that he would be able to come back home and operate his drugstore after living and working in nine different places for the last three years. But his pharmacy business depended on a doctor."

Inquiries from Afar

Because of the growing reputation of the Virginia Council's service, it gets inquiries from doctors in all parts of the country. Texas-born George H. Cooke, for instance, came to Virginia's Chincoteague Island early this year by way of the University of Kansas medical school and an interneship at Fordham Hospital in New York City.

Cooke was the second doctor the Council had found for Chincoteague. After Dr. D. L. LeKites was killed in an automobile accident in 1950, the Council helped the islanders get Dr. Thomas L. Mosby. Then, after practicing a year, Dr. Mosby died at the age of 34. So the Council once again got to work.

Because there's no hospital easily available for emergency cases among the 4,000 people living on the island, the community is building a clinic. This will be shared by Dr. Cooke with another physician, Dr. Henrik Shelley, who has been practicing there for several years.

Six Communities Join

Sometimes Fisher finds it necessary to combine the efforts of two or more neighboring communities in order to attract doctors. But only once has he been inspired to such a stroke of ingenuity as in bringing two young doctors from Delaware this summer to serve six small communities in the eastern section of Rockingham County.

After working for several months with separate programs started by the communities of Mill Creek and McGaheysville, Fisher concluded that neither of them was likely to succeed alone. So he suggested that they join forces and try to interest Montevideo, on the main highway

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between the two communities, in seeking two doctors to locate there.

Before the reorganization was completed, the three neighboring communities of Goods Mill, Keezletown, and Port Republic had also joined in. And when Drs. E. Ashby Woods Jr. and Hugh W. Rule, who were interning at Wilmington, liked the location, the joint committee formed a corporation, sold bonds, and started work on a $10,000 clinic building.

The doctors and their families are planning on settling down in Montevideo in July.

No End to the Job

With the Council's program gaining momentum, there's every reason to believe that Virginia is well on the way toward the final solution of its rural-doctor problem. *But*, warns Fisher:

"Heaven help us if we ever sit back and start to congratulate ourselves, instead of keeping our minds on our work. We're proud of what we've accomplished, but the biggest part of the job is still ahead. And even if the job should be practically finished some day, there'd still be no guarantee that it would *stay* finished. A doctor doesn't have to remain in a community he doesn't like; and there are a great many rural communities that will never, never turn into beds of roses for physicians.

"That's why, after we've settled a physician somewhere, we keep in touch with him and try to straighten out any misunderstandings that may arise. There's as much art to keeping a doctor in a small town as there is to getting him in the first place; but some people can't seem to grasp that part of it."

Planning Does It

What are the basic rules for running a successful physician placement service? Well, there's no magic about them, says Dr. Fisher. They might, he adds, be stated as simply as this:

1. Be sure the community that asks help *needs* a doctor, can *support* one, and will make an unselfish effort to help get him started.

2. Be sure the doctor understands exactly what he's doing and that he won't regret the move and blame you for it.

3. Remember that a placement service can offer invaluable information, advice, and guidance; but that the real decisions should rest entirely with the physician and the community.

4. Don't make the mistake of thinking the job will ever be completely finished.

And, he concludes:

"Whenever a country physician you've helped place can say, after six months or a year, what Dr. Tucker said in Huddleston—'We know we're *needed*, and we're beginning to feel that we *belong*'—you can be sure you're on the right track." END

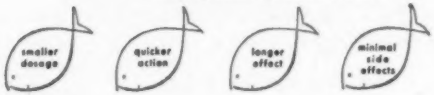
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YOU'LL keep his appetite in check, and at the same time build up his diet-weary spirits, when you prescribe DESOXYN Hydrochloride. Effective in small doses, DESOXYN will usually provide the desired anorexia with a schedule of one 2.5-mg. or 5-mg. tablet before breakfast and another before lunch. Orally, it takes effect within 20 to 60 minutes; average duration of effect from 10 mg. is 6 to 12 hours. Besides obesity, DESOXYN is effective in depressive states and other conditions calling for a central stimulant. In 2.5-mg. and 5-mg. tablets, elixir and 1-cc. ampoules. Abbott

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P-152

How We Apportion Fees Ethically

[CONTINUED FROM 104]

leaving the hospital, unless unforeseen contingencies arise.

"It's barely possible," he points out, "that unexpected complications might extend the period of care you need. In that case, my bill might have to be increased somewhat. But as far as we can see now, there's no indication of that."

Thereafter, the family doctor takes an important and responsible part in the case. He's in the operating room before the anesthetic is administered, reassuring the patient that he'll be present during the operation.

Following the operation, he sees the patient daily, writes orders, changes dressings, and makes daily notes for the record, indicating just what services he has performed.

The Surgeon's Role

The surgeon makes a point of explaining to the patient that the family doctor has a definite and important part in the case:

"As you know, Dr. Jones diagnosed your trouble in the first place," he may say. "I concur fully with his diagnosis, and I'll do what needs to be done surgically. But after that there'll be essential treatments and care, and they'll be Dr. Jones' job. You can be glad of that, because he knows your physical situation better than anyone else."

Except in unusual circumstances, the surgeon doesn't begin the operation until the family doctor has arrived in the operating room and has spoken with the patient.

The surgeon's bill for his own fee may also refer parenthetically to the total fee for the operation, showing the amount due the family doctor. But the latter submits his own bill.

No Basic Changes

That's the essence of our plan—and most of the rest of it, too, except for a few minor details. Actually, the plan makes no basic changes in what has always been the accepted practice at our hospital, except as it stresses the importance of separate bills for the patient.

But in view of the hullabaloo over unethical fee splitting, the plan does have these positive virtues:

¶ It charts a clear course for the G.P. and the surgeon, leaving nothing to chance, and nothing to give rise to suspicion;

¶ It makes certain that the patient receives the best possible care, during and after the operation, at the lowest possible cost;

¶ It assures both the specialist and the G.P. of the fair recompense to which they're entitled for their services; and

¶ It adheres to the letter and the spirit of the Principles of Medical Ethics as we understand them.

Ours happens to be a hospital



To alleviate hypertensive symptoms

In discussing antihypertensive therapy, Grimson and co-workers conclude ". . . hexamethonium seems to be the best present medical approach toward blockade of the sympathetic nervous system."[1]

With Methium (hexamethonium chloride), *orally effective* ganglion blocking makes it possible to:

1. reduce blood pressure to normal or near-normal levels
2. produce marked subjective improvement. Even when blood pressure is not lowered significantly, headaches, dizziness, palpitation and other complaints disappear in the majority of cases.

In addition, "Papilledema and retinal damage usually regress. Cerebral edema and vomiting can be relieved. Pulmonary edema may be lessened or resolved and cardiac hypertrophy diminished."[2]

Methium is particularly indicated in severe hypertension, while in malignant hypertension it is known to stay the rapid progress of the disease.

Induction of lower blood pressure levels and increase of dosage should be gradual. Once maximal therapeutic benefit is obtained, dosage can be stabilized and therapy maintained indefinitely.

Methium is a potent drug and should be used with particular caution when complications exist—impaired renal function, coronary artery disease and existing or threatened cerebral vascular accidents. Complete instructions for the use of Methium are available and should be consulted prior to instituting Methium therapy.

Methium is supplied in both 125 mg. and 250 mg. scored tablets in bottles of 100 and 500.

1. Grimson, K. S.; Orgain, E. S.; Rowe, C. R., and Sieber, H. A.: J.A.M.A. *149*:215 (May 17) 1952.
2. Paton, W. D. M., and Zaimis, E. J.: Pharm. Reviews *4*:219 (Sept.) 1952.

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where for years the staff has worked hard and successfully to keep ethical standards high. Our discipline and *esprit de corps* have always been good. The atmosphere isn't of the sort to encourage laxity or abuse. And our doctors take pride in these things.

Yet, when the A.C.S. unleashed its nationwide crusade with all the uninhibited zeal of a man using a sledgehammer to swat flies on a window pane, we were worried. We felt something was needed locally to protect innocent bystanders from possible injury by flying glass.

No one, naturally, took exception to the condemnations of overcharging, commercialism, and greed with which the crusade was so liberally garnished. The complaint here was that the garnish was too rich and too thick, implying that virtually every doctor was suspect and that any form of fee apportionment was ipso facto evidence of ethical turpitude.

That, of course, just isn't so.

The Local Problems

Although the fee question is bigger than the A.C.S., the College, having brought it up, has a splendid chance to serve the whole medical profession by helping to answer it wisely. This, however, requires a somewhat more realistic approach than the College has yet taken to a problem that is too complicated to be solved by simple fiat.

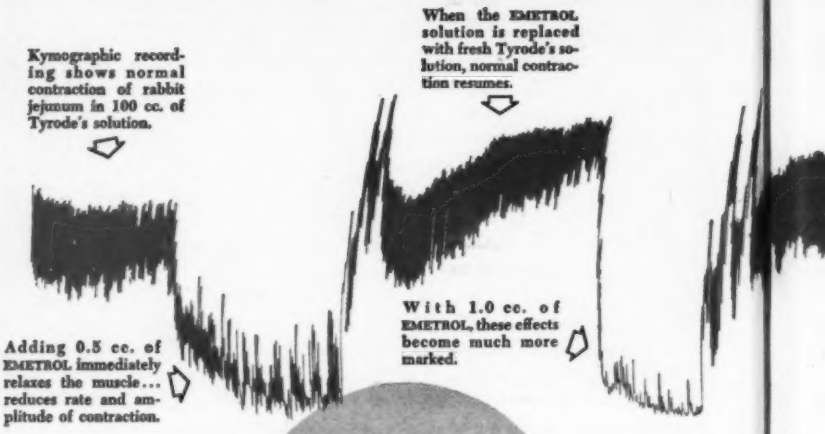
The real work has to be done out where the doctors of America are practicing under conditions that don't always jibe with their leaders' neat formulations. The role of the national leadership should be chiefly to guide and advise the doctors in solving what is not a single big problem but a variety of smaller ones rooted in the local soil.

It won't be easy; but it will, if carried through, have the result of clarifying and strengthening ethical standards all along the line. While fee splitting may have been linked at times with unethical practice, it's foolish to let these occasional evils blind us to the greater evils inherent in any arbitrary ban on ethical fee apportionment.

Right or Wrong?

In our community we've hammered out the best solution we could manage, and with no outside help. It's been suggested that it may run counter to the A.C.S. stand principally in that it recognizes the right of physicians and surgeons to agree on the apportionment of fees. There's an impression among some doctors that the A.C.S. thinks that all such agreements are wrong. We don't share that impression. We think most surgeons in the A.C.S. consider such agreements all right when they're arrived at honestly and openly.

They seem to be right, at least, for our community. Since the time that the guide we drew up was sent out to our staff members—most of



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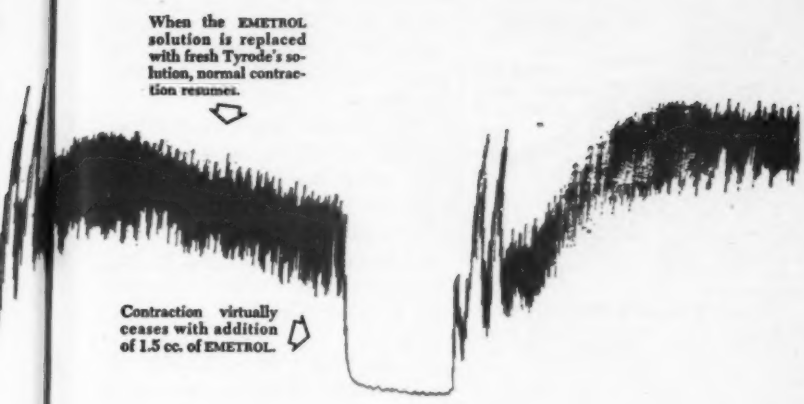
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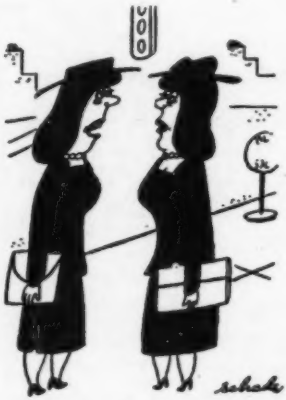
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whom have been following pretty much the same *unwritten* code for years—the word from them has been heartening.

We naturally don't consider our plan a cure-all, or anything more than a first step in the right direction. We hope to improve on it as the way grows clearer. To that end, we'll be glad to receive constructive suggestions from any source, including the American College of Surgeons.

If the leaders of the College actually do get out and around, and if they study the surgeons' problems from the grassroots level, they're pretty sure to come up with the right answers. END



"Sometimes he's better, and sometimes he's worse; but from the way he carries on when he's better, I think he's better when he's worse."



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News

Medical public relations found thriving • Health plans boom • Terms mass chest X-rays overrated • Warns against over-prescribing • Doctor denied medical society membership • Academy drops non-studying G.P.s

Says M.D.s Could Save By Cooperative Buying

Might physicians cut office costs by banding together, through their county medical societies, to buy services and supplies in quantity? Dr. Gervais W. McAuliffe, president of the 6,800-member Medical Society of the County of New York, thinks so.

Take stationery as a case in point, he argues: "Every physician has his own . . . billheads, office forms, and a variety of such items. These he buys as an individual from some small printer, and he pays a top rate because he is buying in very small quantity . . . A printing contract could be signed with one printer for large volume orders . . . With orders placed through the society, the price could be lower . . . and the savings passed along" to the doctors.

Other areas in which McAuliffe thinks that mass buying might save money for individual doctors: magazine subscriptions and bookkeeping services.

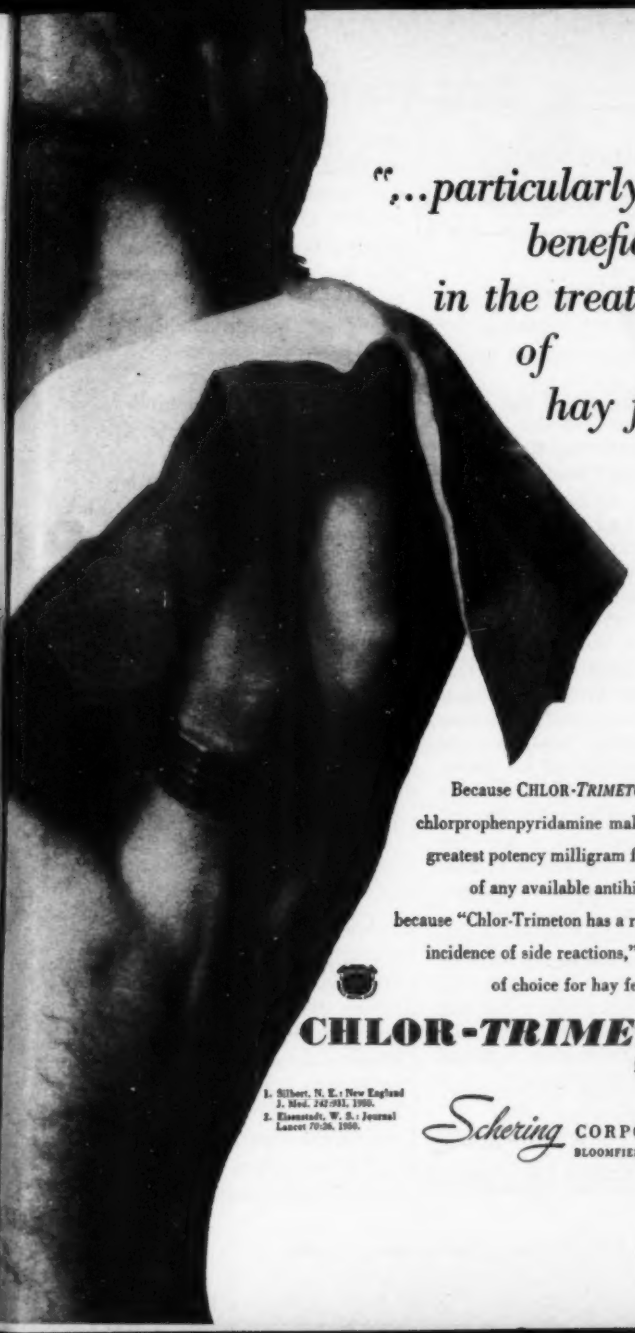
Cooperative buying isn't a new idea; but it's doubtful whether any large professional organization has ever tried it. According to a spokesman for the U.S. Chamber of Commerce, a few trade associations experimented with the idea some years ago, but apparently soon abandoned it. A possible reason for their failure, he suggests, is that "joint efforts of this sort are not looked upon with favor by retailers and other normal sources of supply."

Fund for Students Is Memorial to Doctor

On the day he died, in 1950, Dr. James F. Norton of Jersey City, N.J., wrote a check for $500—his contribution to a needy medical student.

Norton's friends, who wanted to perpetuate his memory, found their inspiration in this last act. So they set up the James F. Norton Memorial Fund, to help other needy boys through their medical studies.

So far, some 400 of the late A.M.A. Vice President's friends



"...particularly beneficial in the treatment of hay fever."[1]

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1. Silbert, N. E.: New England J. Med. 242:931, 1950.
2. Eisenstadt, W. S.: Journal Lancet 70:36, 1950.

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From where I sit *by* Joe Marsh



Pretty "Foxy" Terrier

Talking about dogs the other night — Sandy Johnson topped everything with a tall story about his fox terrier, "Boscum."

According to Sandy, "Comes bird season and that dog won't stir if I take down my *rifle*. Same if it's deer season and I go for my *shotgun*—he won't move, but he's scratching at the door if I so much as look at my *rifle!*"

One day, Sandy decided to fool him. He took *both* his shotgun and his rifle—and swish, Boscum was on his way! Sandy put the guns back and took out his fishing rod. He went outside and there was Boscum—digging for worms!

From where I sit, a dog that can outguess humans is as rare as a human that can outguess other humans. I like a glass of beer but I wouldn't pour you one without first asking. I want to practice my profession the way I think best, but I won't tell you how to do your job. Respecting the other's rights keeps freedom from "going to the dogs."

Joe Marsh

Copyright, 1953, United States Brewers Foundation

have contributed about $14,000 to the fund, according to a recent announcement of its secretary, Dr. Joseph P. Donnelly. And they've pledged to continue giving until the total reaches $25,000—enough, Donnelly believes, to start one deserving youngster through medical school each year.

Already, he adds, four boys are being subsidized by the fund. Loans range up to $1,500 a year; and repayment need not begin until five years after graduation. From that point on, there will be a 5 per cent interest charge, which will help make the fund self-perpetuating.

Says Donnelly: "We plan to lend money to boys who are good students, who are accepted by a medical school, and who really need the money. There are no racial, religious, or other qualifications."

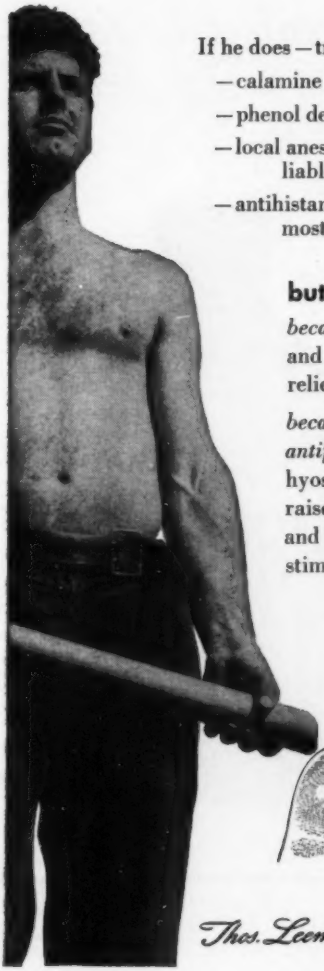
A.M.A. Studies Public Relations Activities

Finds P.R. programs thriving in most local societies

Public relations activities—and P.R. men's salaries—account for an increasingly important share of the money spent each year by county and state medical societies. This fact emerges from an A.M.A. survey of more than 2,000 societies across the country. Analysis of the first 20 per cent of the returns showed that

¶ Twenty state societies (out of forty-five reporting) spend more

he may or may not get poison ivy



If he does — treatment should exclude

— calamine preparations which are ineffective[1]

— phenol derivatives which are irritating[2]

— local anesthetics of the "caine" group liable to cause contact dermatitis[3]

— antihistaminics which may produce some of the most severe reactions due to sensitization[3]

but he can rely on Calmitol —

because Calmitol does not sensitize and is "preferred"[2] by physicians for safe relief of pruritus.

because Calmitol contains specific antipruritic agents — camphorated chloral, hyoscyamine oleate and menthol — which raise the threshold of sensory nerve endings and skin receptors, thus inhibiting itch stimuli at the point of origin.

1. Goodman, H.: J.A.M.A. 129: 707, 1945.
2. Lubowe, I. I.: New York State J. Med. 50: 1743, 1950.
3. Nomland, R.: Postgrad. Med. 11: 412, 1952.



the non-sensitizing antipruritic

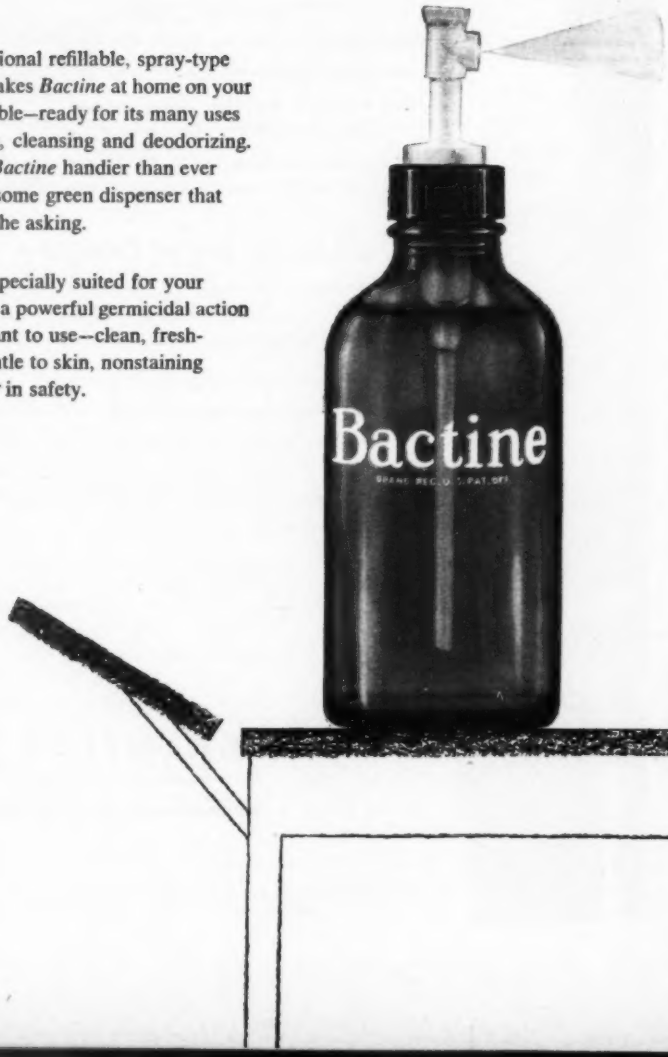
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Skin preparation	Sunburn	Poison ivy

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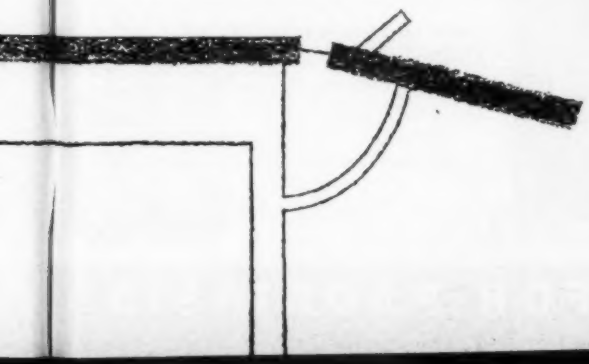
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RIASOL FOR PSORIASIS

than $10,000 a year on public relations alone; two of these allot over $50,000 to their P.R. programs. Five of them earmark over 30 per cent of their total budget for such activity. And, even more surprisingly, several county associations with fewer than 100 members report that *they* devote more than 30 per cent of their budgets to public relations.

¶ Sixteen state societies employ a full-time public relations man; and thirteen use more than one man. (But almost all the very small medical societies get by without paid public relations help. Of those that use P.R. men, most employ independent counsel; others have part-time help.)

¶ Salaries paid to full-time public relations men average $6,000 to $8,000; but five state societies pay their directors of public relations at least $10,000.

Is Anything Wrong With Modern Doctors?

Nothing, says one physician; but two others disagree

Proving once again that it's difference of opinion that makes consultations, three doctors have come to as many conclusions about today's medical men. The question under consideration: Has the modern doctor lost the human touch so characteristic of his predecessors? The answers:

¶ Medicine has changed greatly

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in the last twenty years, but the medical *man* hasn't, says Dr. Frank Weiser, writing in the Detroit Medical News. The average physician, he insists, "is the same human being, the same kind old doctor he has always been." And he maintains that to say otherwise is to spread "an inspired line of hokum" intended to put across the socialistic propaganda that under free enterprise medicine has become dangerously impersonalized.

¶ The trend toward specialization *has* dehumanized physicians through exposing them to too many years of institutional practice, charges Dr. Don Branham, in The Bulletin of the Oklahoma County Medical Society. As a solution to this problem, he proposes an apprenticeship under a general practitioner for each aspiring specialist.

¶ Taking a rather middle-of-the-road stand, Dr. Paul B. Magnuson feels that today's physician is no longer regarded by patients as a combination "friend and comforter . . . father confessor, adviser on family relations, psychiatrist and dispenser of medicines." Yet, says the former Veterans Administration medical director and head of the Presidential commission on America's health needs, we wouldn't want to turn back the clock.

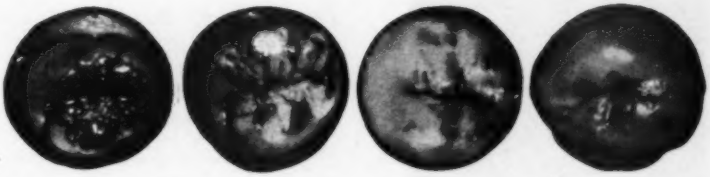
Yesterday's doctor, writes Magnuson in Collier's, "was not the kind of doctor we now need. The kind of man, yes; but not the kind of doctor." For example, his training lasted

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References: 1. Schwartz, J.: *Furacin Vaginal Suppositories in Pre- and Postoperative Treatment of Cervix and Vagina*, Am. J. Obst. and Gynec. 63:579 1952 • 2. Doyle, J. C.: *Vaginal Infections and Their Management*, Urol. & Cutan. Rev. 55:618, 1951.

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I. Phillips Frohman
His percentage was 4.4

a quarter as long as today's; and his equipment—even including his horse and buggy—cost no more than three or four hundred dollars.

"To the old-time doctor," says Magnuson, "the practice of medicine was an art, partly because not much was known about science. Today, the science takes precedence over the art. Both ways are wrong. The time has come when we doctors must bring the art and the science of medicine into sensible relationship. It can't be done by law. But it can be done."

Health Plans Grow

One American in four now carries Blue Cross insurance; one in six is covered by Blue Shield. The all-time high figures (44 million with hospital insurance, 25 million with medical and surgical coverage) were proudly announced at the recent joint conference of the plans in Hollywood (Fla.).

Doctor Says Mass Chest X-Rays Are Overrated

Claims that the G.P. is more effective in uncovering TB

Mass chest X-rays play an important role in preventive medicine, but, says one Washington (D.C.) G.P., the individual family doctor is likely to uncover proportionately more tuberculosis cases, for example, than can any survey team.

In the first six months of last year, says Dr. I. Phillips Frohman, in a recent issue of the Medical Annals of the District of Columbia, he "took X-ray films of the chests of eighty-nine patients in the 3-to-76-year-old age group . . . and discovered four cases of active, advanced tuberculosis . . . and two cases of silicosis. The percentage of diagnoses was approximately 4.4."

In a concentrated, six-week drive during the same period, he claims, mobile X-ray units turned up only thirteen cases of active TB among nearly 11,000 Washingtonians, whose ages ranged from 15 to 45. "This," he adds, "is approximately one-tenth of 1 per cent, a small figure for so large an investment."

Why did the general survey discover a far smaller percentage of

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cortisone for inflammation, neomycin for infection:

Each gram contains:
Cortisone Acetate . . . . 15 mg.
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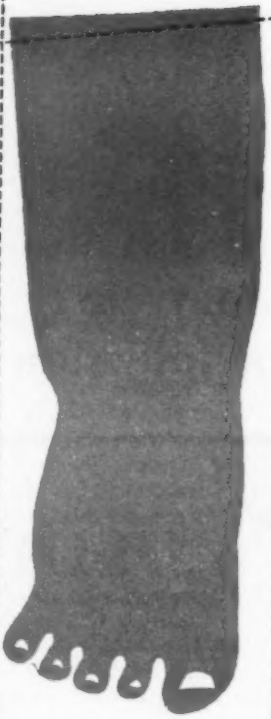
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*Stead, E. A., Jr., in Cecil, R. L., and Loeb, R. F.: Textbook of Medicine, ed. 8, Philadelphia, W. B. Saunders Co., 1951, p. 1065.

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cases than did Dr. Frohman? Because, he suggests, he reached two major groups of people who rarely submit to a general survey—children under 15 and adults over 55.

Since the only opportunity for a thorough examination of such individuals usually comes when they're ill, Frohman urges family doctors to look for TB even when the specific complaint has nothing to do with it. And he recommends that hospitals make it "routine and required practice" to take a chest X-ray of all patients. This, says Frohman, would be "the most important survey of all."

Says Most Internes Now Choose Own Hospitals

Some 6,000 brand new doctors will begin their medical careers as internes on the first of next month—85 per cent of them in hospitals of their own choice.

The chief reason why so many young doctors are getting the interneships they want is to be found, of course, in the national program to match internes and hospitals. Now entering its second year, the matching plan has been remarkably successful.

But the placement figures, while spectacular, may be a bit misleading. Why? Because students who shop for interneships have found that they're in a buyers' market; this year, for example, there were only 6,033 candidates for 10,971 jobs.

Even so, comments the Journal of Medical Education, the matching program has lessened difficulties and "has gained increasing support from . . . hospitals" as well as students. Says the journal: The plan has been found "impartial and orderly . . . in the normal competitive American fashion."

Doctors Help Patients Vote in Bed

In an effort to get out the shut-in vote in future elections, many physicians are urging their state legislatures to permit absentee balloting by hospitalized patients. And as evidence of how such balloting is conducted, The Modern Hospital cites what happened in Missouri—where this type of voting is legal—last November.

Here's what St. Louis doctors, nurses, Blue Cross officials, and hospital clerks teamed up to do:

1. They passed out cards explaining that patients could vote if they applied for ballots.

2. They gave applications to those patients who requested them.

3. Doctors signed the applications and filled in explanations of why their patients couldn't get to the polls.

4. The applications were taken to election offices, and ballots were brought back to the patients.

5. Hospital notaries witnessed the balloting.

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tine, St. Louis medical men were instrumental in adding several thousand votes to Missouri's election total.

Business Slow for This Grievance Committee

The grievance-committee idea has evidently caught on with doctors everywhere. But are laymen flocking to such committees to air their complaints? Apparently not—at least in one area.

According to a report in The Nashville Tennessean Magazine, the grievance committee sponsored by Davidson County (Tenn.) doctors has been confronted with only seven cases in two years. All seven were complaints about fees; and all were settled without resort to a formal hearing of the committee (which consists of three physicians, a businessman, and a representative of labor).

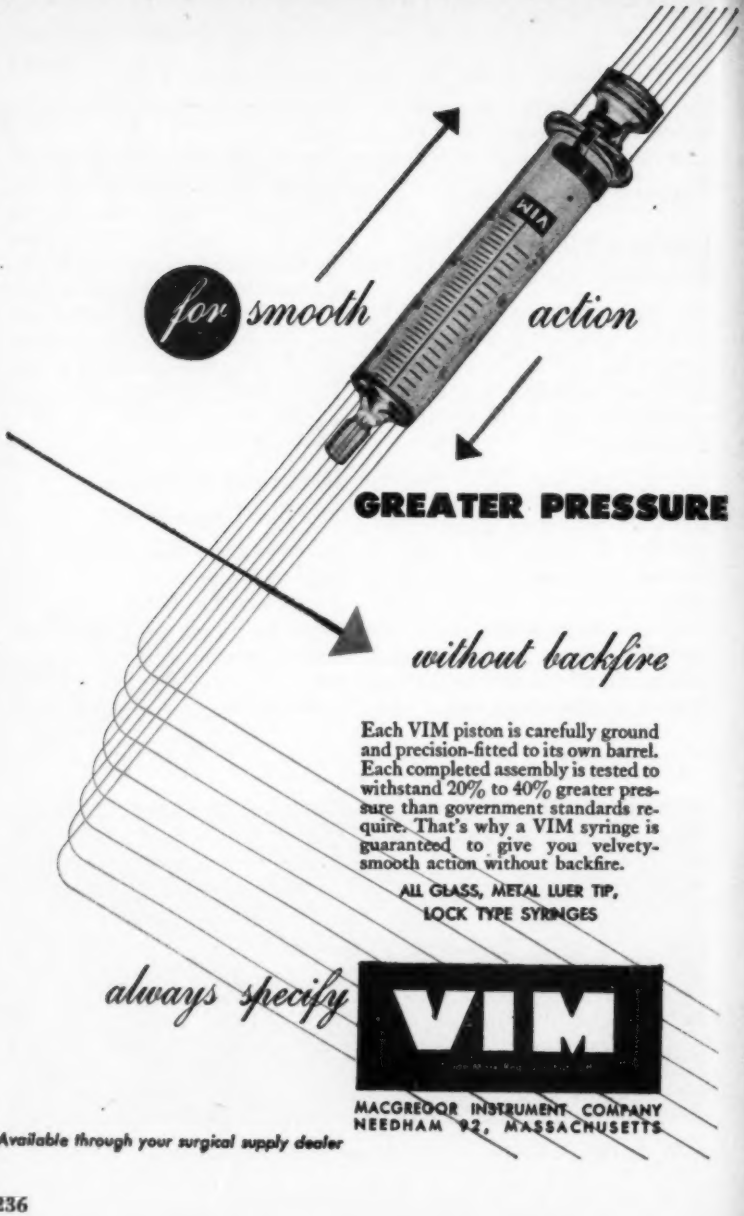
Its chairman, Dr. Thomas F. Frist, indicates that his committee has had easy sailing in other ways, too. "In every case," he says, "it has been simply a matter of getting both parties to understand the point of view of the other. When the patient sees that the doctor's charge is reasonable, he is invariably willing to pay. The doctor is also willing to correct any error."

If Patient Is Dying, Say So, Urges M.D.

In almost every case, the dying patient should be told just where he stands, says Dr. Philip J. Vogel, a California neurologist. Unless you're dealing with the very young, very old, or those otherwise incapable of understanding, a tactful statement



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of the facts is the best way to handle the situation, he adds.

But, warns Vogel, the physician should be careful not "to place any time limit on the patient's life." After all, he points out, "a cure for his ailment may be found tomorrow." So the physician can be both frank and truthful without removing all possibility of hope from the patient's mind. Meanwhile, however, says the Californian, a dying person "has the right to put his affairs in order and to adjust the rest of his life to his own liking."

'Needless' Prescribing Deplored by M.D.

Cites misuse of drugs to fight self-limited infections

When a child takes sick, his parents don't count costs; they want his recovery at any price. This fact, says pediatrician John A. Washington, "places upon us [doctors] the responsibility of not straining a limited family budget" with unnecessary drug bills.

Yet it's undeniable that physicians do tend to over-prescribe antibiotics in particular, says Washington, who is Assistant Clinical Professor of Pediatrics at the George Washington University School of Medicine. And he cites the treatment of the "summertime virus disease, herpangina" as a case in point.

"Like the common cold," he explains, in the Medical Annals of the District of Columbia, "its duration is the same whether it is treated or not . . . Because the natural course of the febrile stage of herpangina is twenty-four to forty-eight hours, it is the type of disease which one or two shots of penicillin seem to cure. Thus a physician, at the start of an epidemic, is deceived into believing that antibiotics are useful . . . He may go through an entire summer prescribing drugs unnecessarily."

With other ailments, too, Washington declares, "we easily deceive ourselves into believing that we are curing acute infections which actually are self-limited and against which all antibiotics are equally ineffectual . . . We seem to ignore the fact that the human race survived remarkably well prior to [wonder drugs] and that hospital records of former years are full of charts showing twenty-four and forty-eight-hour recoveries due to those almost forgotten agents, the natural antibodies."

His advice to his colleagues, then: Consider the need for drugs before you prescribe, and you'll hold down "the drug bills . . . faced by the breadwinner."

Study Plus Fun

On the theory that study and pleasure *can* be mixed, some Eastern doctors are planning to hold open-air post-graduate courses at Starlight (Pa.) this summer. While they catch up on medical advances, in the cool

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of the morning, their wives will enjoy lectures on interior decorating and home economics. Afternoons will be given over to recreation. The program isn't officially sponsored; but the Wayne and Pike County medical societies have expressed interest in it.

Society Bans M.D. Who Defied Congress

Two years ago, young Ruth Bleier of Baltimore sat in a Washington witness chair and faced the House Un-American Activities Committee. Miss Bleier, then a medical student, had headed the Maryland Committee for Peace, which the Congressional committee called a Communist organization. What the Congressmen wanted to know was whether Miss Bleier was a Communist. She refused to answer.

This year, Ruth Bleier—now 29 years old and a doctor—applied for membership in the Baltimore City Medical Society. According to Dr. Wetherbee Fort, president of the society, a number of objections came in by letter and telephone. Fort has withheld details about the objections; but, in any event, he says, the board of censors "found it necessary to withdraw its endorsement" of Dr. Bleier.

Calling it the "ultimate irony that my work for peace" should result in rejection by the society, Dr. Bleier adds: "I am shocked. They have chosen to disregard professional competence and integrity as the consideration for membership and substituted instead their opinion of the alleged political views of an applicant. They have abandoned the traditional concept of freedom of scientific inquiry."



Ruth Bleier
Her ideology questioned

A.A.G.P. Drops Doctors Who Didn't Study

The American Academy of General Practice apparently meant business when it prescribed fifty hours a year of post-graduate study for each of its 16,000 members. Failure to comply with the regulation has cost 464 doctors their membership in the organization.

"The entire purpose of the formation of the academy five years ago

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was to raise the standards of general practice," says Dr. R. B. Robins of Camden, Ark., A.A.G.P. president, in explaining the action. The family doctors dropped from the rolls "just haven't kept up with academy standards and requirements," he adds.

Alcoholism in Industry Cut by Joint Effort

Industry and medicine are now cooperating in an all-out effort to combat alcoholism among workers. And by combining forces, they appear to have enjoyed signal success in coping with the problem, according to a recent statement of the Consultation Clinic for Alcoholism.

The clinic, staffed by three psychiatrists, an internist, and a psychologist, is a cooperative venture of the Institute of Industrial Medicine of the New York University-Bellevue Medical Center and several companies—among them, Consolidated Edison.

In its first year of operation, it reports, it treated fifty-one Consolidated Edison employes. All but ten of these have learned to control their drinking—and have thus managed to retain their jobs.

Blue Shield Payments

Latest Blue Shield figures show that doctors receive an average of $60 a delivery from the plans; but payments vary widely from place to place. In Newark, N.J., for example,

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The dependable hypotensive response produced by Solution Intramuscular Veriloid quickly relieves the distressing symptoms of critically elevated blood pressure. Injected deep into a muscle, a single dose of Solution Intramuscular Veriloid leads to a significant fall in blood pressure. Attaining its maximum effect in 60 to 90 minutes, this drop persists for 3 to 6 hours. Through repeated injections, the tension may be kept depressed for many hours or even days if necessary.

During this period, continuous relief is afforded the patient. Thereafter, suitable oral medication should be given in an effort to maintain the relief so achieved.

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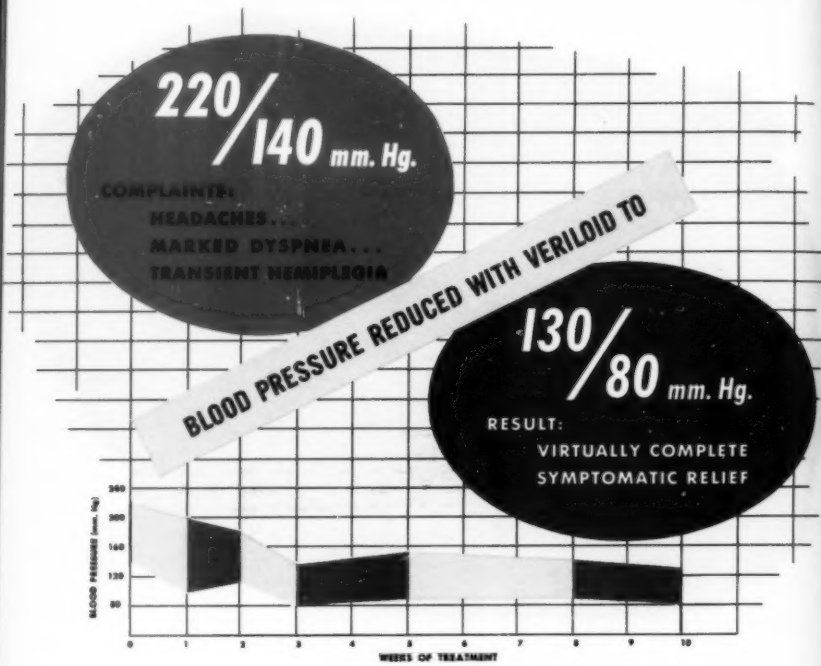
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Not every patient shows this spectacular response to oral Veriloid. However, a sufficiently large number do, warranting the administration of this hypotensive agent to every patient with elevation of blood pressure sufficient to require treatment. For this reason, the suggestion has been made that all hypertensive patients should be screened to identify those who respond well to veratrum preparations.**

*Kauntze, R., and Trounce, J.: Lancet *2*:1002 (Dec. 1) 1951.
**Page, I.H.: Pennsylvania M. J. *55*:737 (Aug.) 1952.

Veriloid is available in three dosage forms for oral administration:

Veriloid (plain) in 1, 2, and 3 mg. scored tablets; starting dosage 9 to 15 mg. daily, to be adjusted according to response and tolerance.

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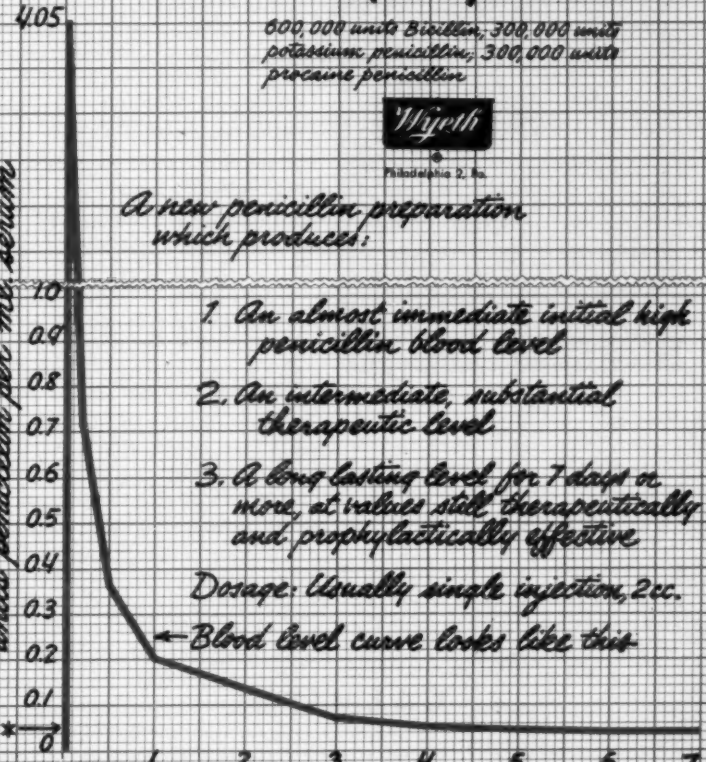
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*0.03 units—effective penicillin level against k. strep.



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1. Goodman, H.: J.A.M.A. *129*:707, 1945.
2. Lubowe, I. I.: New York State J. Med. 50:1743, 1950.
3. Nomland, R.: Postgrad. Med. *11*:412, 1952.



the non-sensitizing antipruritic

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says the National Association of Blue Shield Plans, doctors averaged almost $128 for obstetrical services in a recent month. In the same period, on the other hand, physicians in Chapel Hill, N.C., got about $34 a delivery.

Hold the Phone; 'Dr. Jerkheimer' Calling

Ever answer your phone only to find another doctor's secretary on the other end, asking you to wait a minute, please? You may be busy with a patient, but you're compelled to drop everything and wait until your colleague is ready to talk to you. Dr. Max Thebaut of Oakland, Calif., has a name for such a boor: he calls him "Dr. Jerkheimer."

Dr. Jerkheimer has an inexhaustible "bag of tricks," according to Thebaut. Take, for instance, one "cutie," which is even "more subtle in its discourtesy":

When another doctor calls *him*, Jerkheimer makes the caller "wait an interminable length of time." Then, when Jerkheimer finally picks up the receiver, he "doesn't say 'Hello.' Instead, he places his mouth close enough to it so that his colleague can hear the final phases of a conversation he is having with someone in his office."

Concludes Dr. Thebaut, writing in a recent Bulletin of the Alameda-Contra Costa Medical Association: "Why, oh why, Mr. Anthony, don't some people realize that others

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might be busy, too? . . . All I can say is, I hope certain people I know read this and mend their ways. My coronaries aren't as resilient as they used to be."

G.P.s Say They Prefer Morning Study

Most doctors recognize the need for refresher courses; but can they also agree on a convenient time and place for such training? In an effort to find out, the St. Louis chapter of the American Academy of General Practice recently asked its members to state their preferences.

Three out of four said they prefer post-graduate work in the morning. A few apparently liked evening courses. Only one in ten voted for Sunday studies.

There was less agreement on the most convenient *place* for post-graduate work. Thirty-four per cent of the St. Louis G.P.s voted for courses in medical schools. One in four preferred hospitals; and almost as many said they'd like to study at their medical society building. Twenty per cent voiced no preference one way or the other.

'Bride' Is Man

Doctors may be happy to learn that many lawmakers agree with them that marriage between males is a biological impossibility. While this is usually taken for granted, some Maryland legislators say they'd better get it down in writing—as a state law.

Reason for their action: When an unidentified soldier allegedly discovered that his "bride" of a year wasn't a woman, he asked Maryland's Attorney General whether or not he had grounds for annulment. And the Attorney General—not surprisingly—found that his search for a law to cover the situation was in vain.

Just how the soldier's "wife" managed the disguise (and how the soldier eventually pierced it) hasn't been revealed.

Atomic Hospital Joins War on Cancer

Doctors have welcomed a new weapon in their fight against cancer: the eight-story Argonne Cancer Research Hospital in Chicago. Built at a cost of over $4 million by the Atomic Energy Commission, the new institution is designed to house every known radiation source needed by medical men in their study of the disease.

Despite its size and cost, the hospital has room for only 56 patients. They will, it announces, be handpicked from among those whose cases are deemed of top interest to researchers. And, once admitted, they'll be confined to rooms with eight-inch-thick concrete walls—to prevent the spread of radioactive contamination.

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Panthenol, equivalent to of calcium pantothenate	10.0	mg.
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Folic acid	2.0	mg.
Nicotinamide	100.0	mg.
Vitamin E (as mixed tocopherols natural)	10.0	mg.
Inositol	30.0	mg.
Choline—from choline bitartrate	30.0	mg.
Biotin	0.1	mg.
d-Methionine	20.0	mg.
Cobalt—from cobalt sulfate	0.1	mg.
Copper—from copper sulfate	1.0	mg.
Fluorine—from calcium fluoride	0.025	mg.
Iron—from 4 gr. ferrous sulfate exsic.	76.2	mg.
Calcium—from dicalcium phosphate	165.0	mg.
Manganese—from manganous sulfate	1.0	mg.
Iodine—from potassium iodide	0.15	mg.
Molybdenum—from sodium molybdate	0.2	mg.
Potassium—from potassium sulfate	5.0	mg.
Zinc—from zinc sulfate	1.2	mg.
Magnesium—from magnesium sulfate	6.0	mg.
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neer in atomic energy research, operates the hospital under the direction of Dr. Leon O. Jacobson. But the A.E.C., not the university, will pay Argonne's annual bill: probably about $1 million.

M.D.s Hopeful Congress Will Limit Tax Power

Proposed amendment would put ceiling on income levy

Many doctors are pinning their long-range hopes for Federal tax relief on a proposed Constitutional amendment that would severely restrict the Government's power to tax. If the amendment were adopted, the U.S. tax bite on individual incomes would be limited to a 25 per cent maximum rate in normal times. In addition, no Federal inheritance or gift taxes would thereafter be permissable.

The measure, known as the Reed-Dirksen amendment (H.R. 103 and S.R. 23), takes its name from Representative Chauncey W. Reed of Illinois and Senator Everett M. Dirksen, also of Illinois. These two Republican Congressmen collaborated on a somewhat similar proposal in 1951.

The present bill differs from the 1951 measure in one major particular: The earlier bill provided that in time of war or other emergency, the Government could raise the ceiling on income taxes to 40 per cent; but the bill now under consideration

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would allow the maximum tax to be increased to *any* level on a three-quarters vote of both houses of Congress.

The current bill also provides, however, that if the ceiling *were* raised in time of emergency, the top level could not exceed the lowest rate by more than 15 percentage points. For example, if Congress raised the top tax limit to 50 per cent of an individual's income, the bottom rate would have to be at least 35 per cent.

Backers of the proposed amendment (including the A.M.A., the American Bar Association, and the National Association of Manufacturers) are particularly enthusiastic about this last provision. Gearing the top tax rate to the minimum one, they say, would encourage all taxpayers to urge Government economy and consequent tax reductions.

The Reed-Dirksen proposal isn't the only one of its kind before Congress. But many doctors, lawyers, and businessmen seem to regard it as the best one. Even so, its chances of becoming law soon are slim. For one thing, many of the state legislatures that would have to pass on such a Constitutional amendment aren't scheduled to convene again for two years.

Limited Papal Approval Goes to Psychotherapy

Psychoanalysts may now find less opposition to their efforts to treat Roman Catholic patients. On some occasions in the past, segments of the Catholic press have been openly hostile to psychoanalysis; but in a recent statement, Pope Pius XII has

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given qualified approval to the practice.

Granting the need for such treatment, the Pope's 4,000-word statement nevertheless makes clear his view that "there are secrets which must never be divulged—even to a doctor." And he warns psychoanalysts not to try to banish a sense of guilt in patients by telling them that there is no sin. The ailing patient, he adds, should always be directed toward God and toward "sacramental absolution by a priest."

In spite of such qualifications, the Vatican's approval of psychoanalysis as a legitimate form of medical treatment has been welcomed by many doctors. It's a big step forward, they say, in clearing away misunderstanding between Roman Catholics and one branch of medicine.

Manhattan Gets Hospital!

With gold surgical scissors, Governor Thomas E. Dewey of New York recently clipped a streamer of gauze at the entrance of a new building in downtown New York City. The significance of the operation: It opened Manhattan's first voluntary general hospital in twenty years.

Doctors found the eighty-story, 170-bed Beekman-Downtown Hospital comfortable but not unusual. "Frankly," says Dr. Robert H. Kennedy, surgical director and chairman of the medical board, "we made

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a point of not doing anything that hadn't been proved elsewhere."

Beekman-Downtown serves a daytime financial district population of about a million. But the area it serves also has a residential population of some 50,000.

Sets Pace With Plan to Meet Atomic Disaster

Los Angeles doctor calls his city 'well ahead of most'

A few months ago, Dr. Frank F. Schade, chairman of the Committee on Public Health and Medical Services of the Los Angeles County and Cities Civil Defense Planning Board, went to Kansas City for a national meeting of men who have responsibilities like his. He hoped to get some pointers, he says; "but after a while I discovered that it was *I* who was answering most of the questions. It was fairly clear that Los Angeles was well ahead of most cities in this field."

Why are the California physicians so much better prepared for atomic disaster than their colleagues in other parts of the country? Because, says Dr. Schade, they've done some thorough planning. During the past two years, he reports, they've taken the following positive steps:

1. They've organized their region into zones, in each of which they've clearly assigned responsibility for hospitals, public health, supply,

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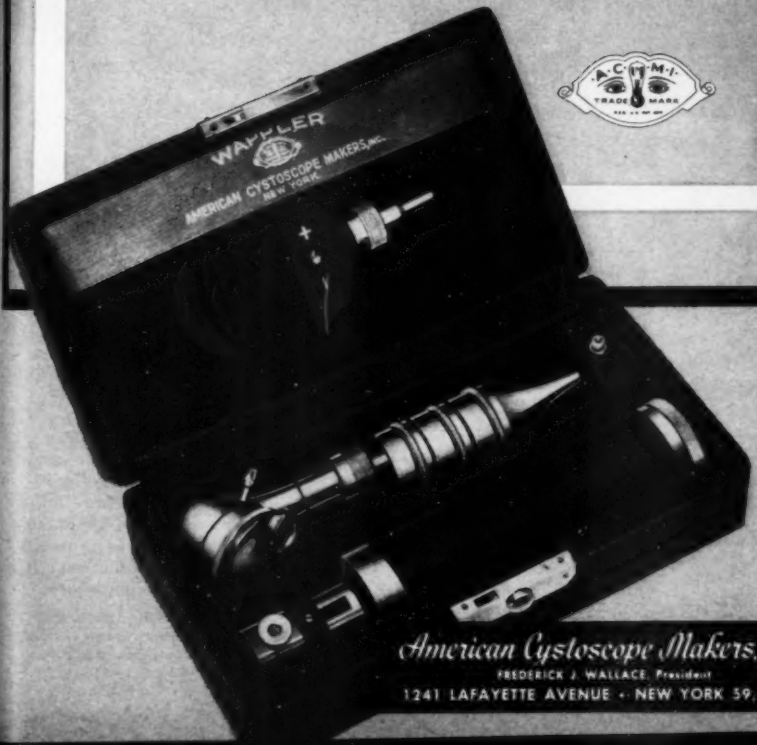
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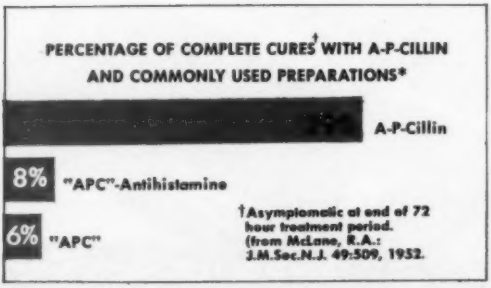


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†*Temperature over 100° F. with other symptoms of acute upper respiratory infection.*



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* 97.5% of cases completely asymptomatic or improved within 72 hours. McLane, R. A.: Clinical Evaluation of Combined Drug Therapy in Acute Upper Respiratory Infections, J. M. Soc. N. J. 49:509, 1952.

transport, communications, personnel, and intelligence.

2. They're ready to man these areas in depth, since at least three persons are trained to handle every job.

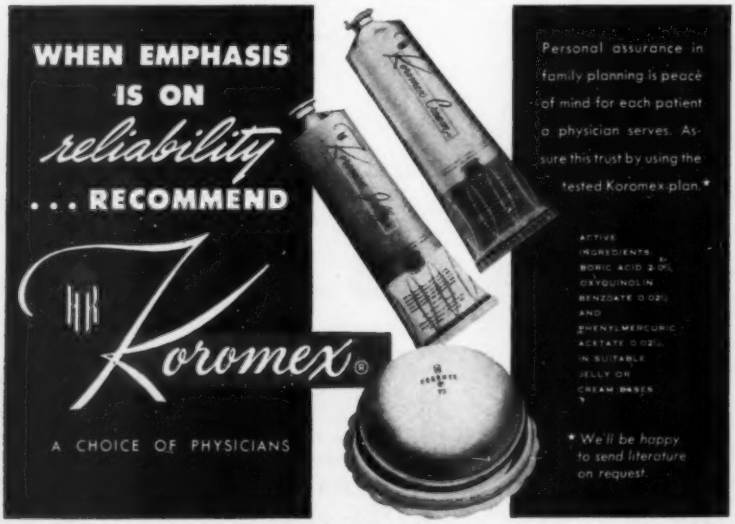
3. With Federal and state funds, they've bought supplies and equipment for 276 mobile aid stations.

4. They've set up a centralized card file of the names, addresses, and telephone numbers of all medical men in the area. Each card also notes the doctor's specialty, if any, as well as the name of the hospital nearest his office.

5. They've pin-pointed areas for mobile aid stations and casualty collecting posts—all of which would be manned and ready to act immediately upon notification of impending need.

If atomic warfare should come, says Dr. Schade, all hospitals in the Los Angeles area stand ready for an evacuation of some four-fifths of their patients. By transferring (to selected schools, churches, and hotels) patients well enough to be moved, the hospitals would then be prepared for an influx of disaster victims. In addition, the committee has made arrangements for setting up three emergency obstetrics hospitals in the area.

According to Schade, all these plans have been worked out by a volunteer committee of physicians, public health officials, nurses, druggists, and dentists. At first they met

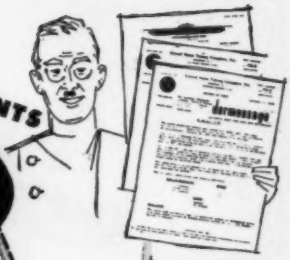


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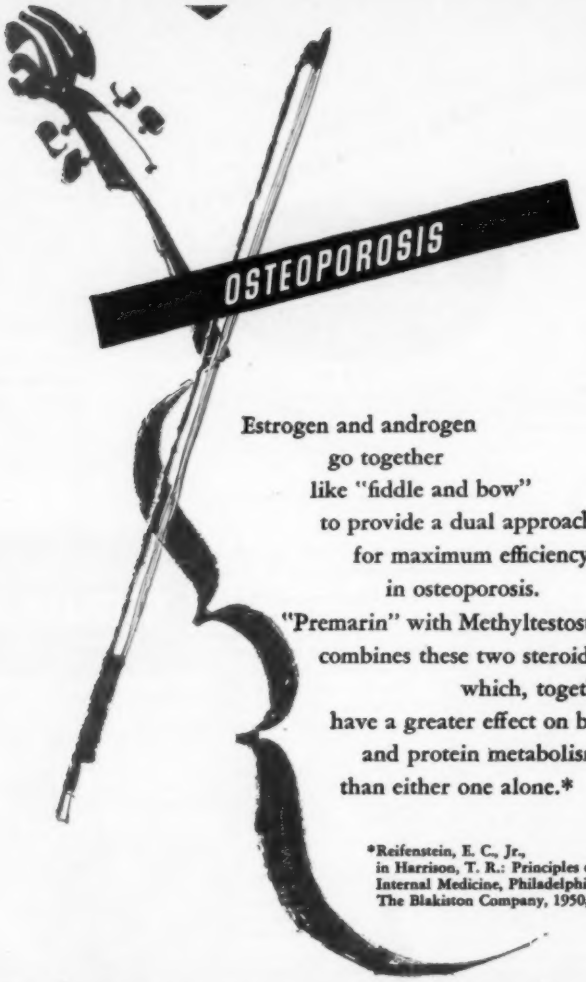
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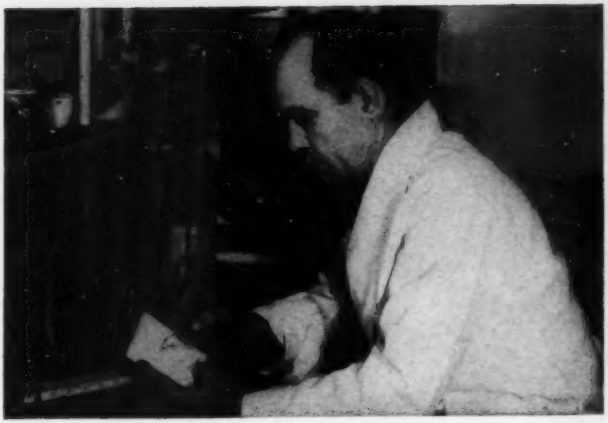
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*Reifenstein, E. C., Jr.,
in Harrison, T. R.: Principles of
Internal Medicine, Philadelphia,
The Blakiston Company, 1950, p. 655.

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Antonio Cortizas
He went from sculpture to scar tissue

three times a week. Now, he says, with everything under control, the volunteers meet just twice a week—over sandwiches and coffee.

M.D.s Aided by Artists With Tattoo Needles

Plastic surgeons value their ability to mask scars

To men like Antonio Cortizas and Frank Eliscu, medicine offers a unique outlet for creative talent. Though neither is a doctor, both are masters of the tattoo needle; and they've had strikingly parallel, though completely individual, careers.

As a master sergeant in the U.S. Army Medical Department, Cortizas specializes in camouflaging the scar tissue left after plastic surgery, by tattooing a pigment that matches skin-color. According to a Reader's Digest article, he has "successfully applied this technique to more than 150 patients"; and doctors whom he has trained have used it on several hundred others.

As an artist and sculptor, Cortizas has seen his work exhibited at New York's Metropolitan Museum of Art. But he never handled a tattoo needle until he joined the Army in 1942. Then, while stationed at O'Reilly General Hospital in Springfield (Mo.), he began to study the tattooing process as a possible aid to soldiers with reconstructed—but badly scarred—faces. After a long period of experimentation, he de-

simple!



Convenience of ready-to-use single-dose disposable cartridges for use with the Pfizer Steraject Syringe. Handy for office, house calls and hospitals. Among the widely used antibiotic formulations available are:

Penicillin G Procaine Crystalline in Aqueous Suspension: 300,000 units, 600,000 units, and 1,000,000 units.

Permapen* Aqueous Suspension (brand of dibenzylethylenediamine dipenicillin G): 600,000 units.

Combiotic* Aqueous Suspension: 400,000 units penicillin G procaine crystalline and 0.5 Gm. dihydrostreptomycin.

Streptomycin Sulfate Solution: 1 Gm.

Dihydrostreptomycin Sulfate Solution: 1 Gm.

Antibiotic Division, CHAS. PFIZER & Co., Inc., Brooklyn 6, N. Y.



Frank Eliscu
A special talent for skin-deep problems

veloped a technique for tattooing the skin with matching pigments in a manner that met the requirements of Army doctors.

Since 1947, Cortizas has been assigned to the Armed Forces Institute of Pathology in Washington, D.C. He heads the sculpture branch of the institute's Medical Illustration Service. And—under medical supervision—he not only continues his skin camouflaging but also engages in such delicate procedures as restoration of color to the corneas of injured eyes. On occasion, he even takes his tattoo needle—and new hope—to disfigured patients at the Public Health Service leprosarium in Carville (La.).

As with Cortizas, it was war service that turned Frank Eliscu from the fine arts to tattooing. A sculptor, whose work had won him considerable praise, Eliscu became a sergeant in the Army Medical Department at Valley Forge (Pa.) General Hospital. While there, he began his career as a lay technician by making sculptures of the faces of wounded soldiers, to help guide plastic surgeons in rebuilding them.

As the logical next step, Eliscu became interested in masking the discolorations that accompany skin-grafting operations. And so—like Cortizas, but by a different route—he eventually found that he, too, had become a tattoo-artist of a very special kind.

For the past several years, he has been a technician in the plastic surgery department of the New York

Hospital-Cornell Medical Center. There, he specializes in camouflaging facial port-wine stains. He is said to have successfully treated such blemishes in over 300 cases. And M.D.s report that they've learned much by studying Eliscu's methods.

Pool of Medical School Facilities Suggested

Western Senators propose it as answer to regional problem

"Last year, some 20,000 young men in the United States could not enter a school of medicine or dentistry because of the lack of educational facilities." And in the West, where this situation is particularly bad, ten states in the Rocky Mountain area don't "have a single institution of higher learning for the teaching of dentistry."

Presenting this picture to the Senate on behalf of himself and eleven colleagues, Senator Lester C. Hunt (D., Wyo.) has introduced a bill to improve the lot of would-be physicians and dentists in the West.

Hunt, himself a dentist, has asked Congress to permit eleven Western states along with Hawaii and Alaska, to "enter into a compact relating to higher education." Such a compact, he says, would seek "to make all the higher educational facilities in the West available to the citizens from any of the eleven Western states, thereby increasing the possibility for



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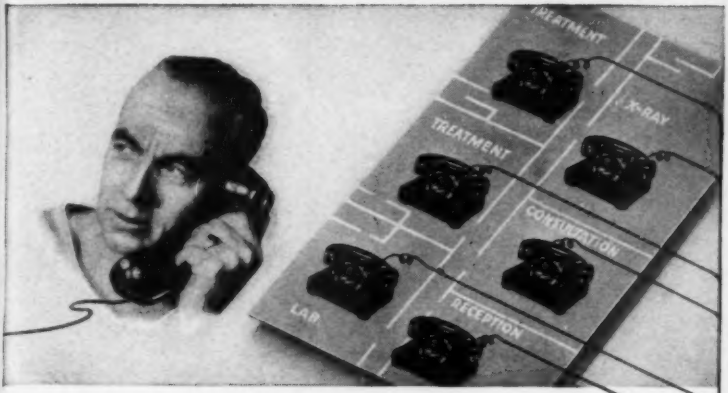
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Inositol	0.75 Gm.
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higher B_{12} potency



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diabetes	frequent + + + +	**frequent** + + +	Methischol as adjunct to diet. Insulin as necessary.
atherosclerosis	frequent + + +	**frequent** + + + +	Methischol and high protein, low fat diet.
coronary disease	frequent + + +	**frequent** + + + +	Methischol as adjunct to high protein, low fat diet and specific therapy.
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higher education, on the one hand—and greatly decreasing costs in many states, on the other."

Passage of his bill, says Hunt, would result in several "concrete benefits":

1. "Established schools would receive a welcome financial boost," since they'd get income from outside their home states.

2. States without training facilities of their own would be able to provide "opportunities for their youth."

3. Doctors trained under this system would help to improve "the health-service picture" in their individual states.

4. The over-all health of the West, as a region, would improve.

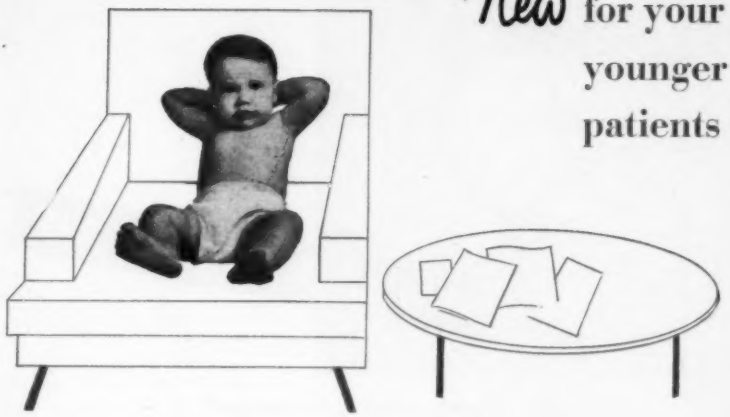
Dentist's Dilemma

It's no fun being a dentist. You can take it from one of their own number, Dr. Loren R. Borland of San Francisco.

The poor D.D.S. knows his patients hate him, says Borland; so he's put on the defensive and becomes a sadist as a result.

It's a vicious relationship by its very nature, adds the San Francisco dentist; for the patient resents being forced to "half-swallow" the dentist's hand, and the dentist lives in constant fear of having said hand bitten.

"Be glad you're an M.D.," Borland tells his medical friends gloomily.



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[1]Vernon, S.: *Nutritional Deficiency, Clin. Med., Oct., 1950, p. 187*

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Memo

FROM THE PUBLISHER

Editor Elected

● I have just sent a memorandum to the officers and staff members of our publishing company that I think will be equally interesting to the 134,000 physician-readers of MEDICAL ECONOMICS:

"William Alan Richardson, Vice President and Editorial Director of Medical Economics, Inc., has been elected an associate member of the Connecticut State Medical Society.

"A resolution proposing Mr. Richardson for such membership was introduced by the Board of Trustees of the society at its annual meeting on April 27, at Hamden, Conn. An affirmative vote for the resolution, cast the same day by the House of Delegates, was unanimous.

"This action confers on Mr. Richardson all the privileges of membership in the society except the right to vote and to hold elective office.

"The Connecticut State Medical Society is one of the oldest in the United States, having been founded in 1792. Rarely are associate members elected (there are only eleven others now living); and in each case the person chosen either is a physician licensed outside the state or has a direct connection with one of the medical sciences (for example, the following Yale faculty members: John F. Fulton, Sterling Professor of Physiology and biographer of Harvey Cushing; Ira V. Hiscock, Director of the School of Public Health; James A. Hamilton, internationally known hospital consultant).

"Certain distinguished foreign physicians and members of such related professions as public health and dentistry have been made associate members of state medical associations in this country. But few—if any—laymen (e.g., economists, editors, businessmen) have ever been so honored.

"While MEDICAL ECONOMICS' plant and offices are in New Jersey, Mr. Richardson's home has long been in Darien, Conn., and many of his forebears settled and founded towns in that state (one of them went on to become the first graduate of Harvard College in 1642; MEDICAL ECONOMICS' editor followed 289 years later, in the class of 1931).

"The fact that Mr. Richardson was elected by the Connecticut State Medical Society in recognition of his contributions to the field of medical economics is evidence of the great importance this subject has attained in recent years.

"I like to think of it as a tribute also to the position of leadership the magazine MEDICAL ECONOMICS has attained under Mr. Richardson's able editorial direction."

—LANSING CHAPMAN

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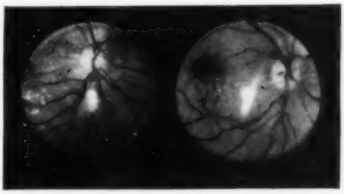
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1. Krantz, J.C., Jr. & Carr, C.J.: The Pharmacological Principles of Medical Practice, The Williams & Wilkins Co., Baltimore, Md., 1951, p. 836.



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